DOCUMENT RESUME

ED 154 111 CE 013 609

TITLE	Hospital Inpatient Education. Survey Findings and Analyses, 1975.
INSTITUTION	American Hospital Association, Chicago, Ill.
SPONS AGENCY	Center for Disease Control (DHEW/PHS), Atlanta, Ga.
PUB DATE	77
CONTRACT	200-75-0542
NOTE	86p.; Some tables may not reproduce well due to small print; For related documents see CE 013 467-483 and CE 013 608
AVAILABLE FROM	Center for Disease Control, Bureau of Health Education, Community Program Development Division, Atlanta, Georgia 30333
EDRS PRICE	MF-$0.83 HC-$4.67 Plus Postage.
DESCRIPTORS	*Administrator Role; Health Personnel; Health Services; *Hospital Personnel; *Hospitals; *Hospital Schools; *Management; *Medical Services; National Surveys; Organizational Development; Patients (Persons); Program Development; Program Effectiveness; Program Planning; Public Health
IDENTIFIERS	Patient Education; United States

ABSTRACT

A national study of inpatient education was conducted in 1975 by the American Hospital Association to obtain a current assessment of organized patient education programs in hospitals in order to guide the subsequent development of effective inpatient education programs. The survey sought information about organizational structures relating to patient education and about specific education programs. A universe of 2,680 hospitals was used for data analysis; to support and clarify survey findings, eleven group discussion meetings were held with staff from eighty-two hospitals. It was concluded that hospitals differ in where they place the responsibility for patient education and in how they undertake the patient education task. Flexibility is required in making management decisions so that these decisions best fit the needs of the hospital. In addition, management must be aware of what is involved in accomplishing the task and how the decisions they make will affect that task. The survey showed that there were many programs developed for specific patient populations that could be obtained and shared. Analysis of those that were obtained emphasized the wide range of sophistication of outlines of programs--for example, the clearness of objectives as well as the correlation of objectives to methods and evaluation. (Twenty-nine appendixes containing materials used in the survey and data analyses are included.) (TA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED154111

CE

HOSPITAL INPATIENT EDUCATION

Survey Findings and Analyses, 1975

AMERICAN HOSPITAL ASSOCIATION

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL
BUREAU OF HEALTH EDUCATION
Atlanta, Georgia 30333
1977

CE 01 3609

HOSPITAL INPATIENT EDUCATION

Survey Findings and Analyses, 1975

AMERICAN HOSPITAL ASSOCIATION

Written by the American Hospital Association in cooperation with the Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, under HEW contract No. 200-75-0542. Available from the Center for Disease Control, Bureau of Health Education, Community Program Development Division, Atlanta, Georgia 30333.

FOREWORD

This report presents the results of the national study of inpatient education conducted in 1975 by the American Hospital Association and funded in part by the Bureau of Health Education, Center for Disease Control. This report provides baseline data at a time when patient education is rapidly developing.

Patient education has been an integral, although not necessarily formalized, part of hospital services for years. In 1973, staff of the former Health Care Facilities Services, Health Resources Administration, Department of Health, Education, and Welfare, stated that approximately 50 hospitals had organized patient education programs. Criteria used were that the hospital had designated a person responsible and a specific budget for patient education activities. The current survey indicates the rapid growth of patient education programs within hospitals defined as those "with goals and objectives concerning education experiences planned for the patient by professional personnel as a component of his care." The 1975 results indicate a "person responsible" in 1,030 hospitals and a "specific budget" in 694 hospitals. An earlier patient education study, conducted in 1972 as part of the AHA's National Hospital Panel Survey, [1] showed 15 percent of respondents answering affirmatively to having patient education programs using the definition above. The 1975 survey using a comparable definition and sample indicated that 2,680 hospitals had at least one program. This represents 46.4 percent of hospitals and an increase of 31.4 percent in just 3 years, indicating a strong trend towards organizing the patient education function within hospitals.

Hospitals are becoming increasingly sophisticated in their management of patient care services. The explosion of knowledge and technology in medical and related fields has offered new tools for the provision of patient care. There is an increase in the quality of patient education needed as a result of the increase in number of available treatments and the increase in the number of patients with chronic diseases. Today's challenge is to use this knowledge and technology in an efficient yet humanistic way to enhance the care given to patients. The goal of the American Hospital Association and Bureau of Health Education is to use their resources to help hospital staff meet their patient education responsibilities with the most effective patient education possible.

[1] AHA Research Capsule No. 7 Hospitals, 46:102, December 1, 1972.

CONTENTS

	Pages
Forword	iii
Acknowledgments	ix
Introduction	1
Methodology	2
Findings and Discussion	4
Part 1. Total Hospital Programs	4
Policy	4
Policy Committees	4
Committee Membership	5
Education Activity Coordination – Department	5
Education Activity Coordination – Coordinator	7
Outside Consultants	9
Dollar Sources	9
Part 2. Specific Hospital Programs	11
Frequency of Programs	11
Staff Involved	11
Initial Assessment of Patient and/or Family	12
Initiation of Program	12
Planning for Individualized Learning	12
Target Population	12
Program Methodology	12
Patient Education Centers	13
Documentation	13
Audit	13
Post Hospitalization	13
Evaluation	14
Variations in Implementation of Specific Patient Education Programs	14
Part 3. Regional and State Variations	16
Distribution of Programs and Administrative Variables	16
Structure of Current Patient Education Programs	17
Variation by Bed Size	17
Summary	18
Part 1. Overall Hospital Programs	18
Part 2. Specific Hospital Programs	19
Conclusions and Recommendations	21
Part 1. Overall Hospital Programs	21
Part 2. Specific Hospital Programs	21
Part 3. Recommendations	22

APPENDIXES

1. Survey of Hospital Inpatient Education 24
2. AHA Inpatient Education Project – 82 Site Hospitals by Bed Size 32
3. Hospital With a Committee That Sets General Policy for All Inpatient Education Programs by Bed Size 34
4. Summary and Interpretation of "Other" Inpatient Education Policy-Setting Committees: Administrative Type 35
5. Summary and Interpretation of "Other" Inpatient Education Policy-Setting Committees: Education Type 39
6. "Other" Policy-Setting Committee Titles, With Membership From More Than One Discipline 43
7. Personnel With Membership on the Hospital Committee for Inpatient Education by Bedsize and Committee 45
8. Rank Order of Personnel With Membership on the Hospital Committee for Inpatient Education 46
9. Number of Hospitals, by Bed Size, With a Department Designated to Coordinate Inpatient Education, by Type of Department 47
10. List of Department Titles Included in "Other Coordinating Department by Bed Size" 48
11. Titles of Individuals Designated To Spend All of Their Time Coordinating Inpatient Education 50
12. Job Titles and Functions Obtained From Participants of the Hospital Group Discussion Meetings 52
13. Use of Consultants To Assist Inpatient Program Planning, by All Hospitals Reporting at Least One Inpatient Education Program 55
14. Number of Hospitals With Separate Billing for Patient Education, by Bed Size and Type of Item/Services Billed 58
15. Number of Hospitals With Budgeted Funds for Inpatient Education, by Bed Size and Dollar Source 59
16. Examples of Utilization of Staff and Staff Time Spend on Patient Education 60
17. Number of Hospitals Using Video Programs and Dial Access Audio Programs by State 62
18. Description of Patient Education Centers Based on Telephone Follow-ups of the Inpatient Education Survey Responses 63
19. Number of Hospitals With Specified Administrative Variables of Patient Education by Census Division and State 66
20. Definition of Structural Variables 68
21. Hospitals Reporting To Have a Person Responsible for Patient Education Activities in Rank Order by State 69
22. Hospitals With Organized Patient Education Programs Reporting To Have a Person Responsible for Patient Education Activities 70

23. Number of Hospitals With Specified Administrative Variables of Patient Education by State 72
24. Number of Hospitals With Specified Administrative Variables of Patient Education by Number of Adult Operational Programs 73
25. Hospitals With Specified Administrative Variables of Patient Education 74
26. Hospitals Having Five or Six Specified Variables Related to Patient Education, by State 75
27. Hospitals With Operational Adult Programs With a Policy, Committee, Person, Budget, Audit, Evaluation; Hospitals With Operational Adult Programs With a Person Responsible 76
28. Number of Hospitals With Low and High Numbers of Inpatient Education Programs, by Bed Size 77
29. Variables of an Overall Hospital Inpatient Education Program, by Bed Size 78

ACKNOWLEDGMENTS

We wish to express our appreciation to the community hospitals that responded to the survey. A special thanks is extended to the 82 hospitals and their staff members who shared their patient education experiences in group meetings and allowed us to review and share patient education programs they developed.

During the data collection and data organizing phase, the project was based in AHA's Division of Information Services, Robert Linde, manager. Lorraine Richter, manager, Department of Survey Research, Catherine Pegole, Project Director, Department of Survey Research, and their staff were responsible for carrying out these aspects of the project.

After this phase was completed, the project was transferred to the Department of Patient and Community Services, Tita Corpuz, manager. Members of this department were involved in the project from the beginning and had primary responsibility for survey content. However, with the change to the Department of Patient and Community Services, project activities became the responsibility of Elizabeth Lee, Staff Specialist for Health Education, Project Director, Jeanne Garvey, Assistant Project Director, and Twyjean Williams, Project Secretary.

HOSPITAL INPATIENT EDUCATION
Survey Findings and Analyses, 1975

INTRODUCTION

There is an increasing awareness that patient education must be a managed function – one that is planned, coordinated, and evaluated – similar to other aspects of treatment, if the patient is to receive maximum benefit and complete care.

The need for management of patient education has come about for many reasons, including:

- Increase in the amount of patient education needed as a result of the increase in number of available treatments and the increase in number of patients with chronic diseases
- Documentation of the importance of patient education in reaching treatment outcomes
- Increase in the use of such tools as problem-oriented medical records and discharge planning
- Activated consumers who have stimulated development of documents such as the *Patient's Bill of Rights*
- Hospital responsibilities that relate to informed consent, liability, and other legal matters
- Documentation that staff activities related to patient education are not coordinated
- Joint Commission on Accreditation of Hospitals' standards related to patient education

The primary purposes of this 1975 inpatient education survey were to:

- *Determine* the extent to which hospitals are managing the patient education function
- *Identify* and document patient education resources
- *Obtain* a data base for future patient education studies
- *Make recommendations* for developing and increasing the number of effective patient education programs

The patient education function requires management at three distinct levels within the hospital setting:

- At the hospital policy-setting level (decisions about patient education support)
- At the program determination and design level (for specific patient populations)
- At the program implementation level (for individual patients)

The inpatient education survey was designed to obtain information about how this process is applied at each of the three levels. The management of patient education is the same as that of other organizational functions and includes assessment, goal-setting, planning, implementation, and evaluation. The management process requires that goals and objectives be identified and documented and that these become the basis for subsequent planning and evaluation. This process provides the conceptual framework for the definition of inpatient education used in the survey: "educational activities with written goals and objectives for the patient and/or family during inpatient hospitilization."

---

* The universe for both studies was defined as all U.S. community, nonfederal, short-term general hospitals.

METHODOLOGY

The Survey of Hospital Inpatient Education conducted by the American Hospital Association was mailed in July 1975 to the 5,770 U.S. community (nonfederal short-term general) hospitals registered with the AHA. Almost 81 percent (4,669) of the hospitals responded (Appendix 1).

A computer edit was developed to check for inconsistent and missing data and for coding and keypunching errors. As a result of the editing procedure, more than 50 percent of the hospitals were telephoned to verify or clarify reported data and request information for missing data. Preliminary tabulations were analyzed by AHA staff and discussed with Jeannette Simmons, D. Sc., Harvard University. Also, preliminary lists of hospitals with specific components, for example, patient education center, telephone dial access, were compiled and analyzed by staff.

Onsite visits had been planned to corroborate findings from the survey. However, state-by-state review of the survey questionnaires indicated that there were geographical clusters of hospitals that had designated well-defined patient education programs. Conducting group discussion meetings of inpatient education coordinators from several hospitals at central locations instead of conducting single onsite visits was agreed upon. Criteria for hospitals to be invited to the discussion meetings were determined, and computer tabulations were used to determine the specific locations for group meetings. To be invited to group meetings, hospital respondents had to have responded positively on the survey to having: (1) at least three inpatient education programs, (2) a person coordinating inpatient education programs, (3) a patient care audit, and (4) an evaluation method.

Hospitals with programs that met the above criteria were sorted into states and counties. Counties that had three or more hospitals were then sorted into one of the five groups according to size of hospital and into clusters of similar hospitals as classified in the *AHA's Taxonomy of Community Hospitals (1974)*.[2]

Eleven meetings were held.

Date	Location	Date	Location
February 10	Chicago, Illinois	March 3	Atlanta, Georgia
" 17	Cincinnati, Ohio	" 5	Miami, Florida
" 19	Detroit, Michigan	" 9	Newark, New Jersey
" 25	Minneapolis, Minnesota	" 11	New Haven, Connecticut
" 27	Grand Forks, North Dakota	" 12	Plainview, New York
		" 18	Los Angeles, California

For each of the hospitals selected to participate in the discussion meetings, the person designated as the "contact person" on the Survey of Hospital Inpatient Education was telephoned and invited to participate. In addition to the hospital personnel invited to the 11 meetings, other persons in the regions were contacted and invited to attend. Respective AHA directors of the regions where meetings were held were invited as were state hospital association staff. Where appropriate, invitations were also extended to metropolitan hospital staff.

Each meeting was a 1-day session (10 a.m. to 4 p.m.) in a hotel in the designated city. AHA staff conducted the discussion meetings using a question-and-answer technique. The purpose of the question sessions was to explore the "hows" and "whys" involved in the development and implementation of patient education programs.

[2] Phillip, P.J., Iyer, R.N. AHA Taxonomy of Community Hospitals. Chicago, Ill. American Hospital Association, 1974.

In addition to the stated objectives of information gathering, the meetings resulted in the following outcomes:

- The sharing of information among participants
- A commitment to future involvement in the patient education project by participants
- The designation of resource people to AHA staff for future institutes and for referrals.

As a result of the meetings, AHA obtained patient education information from 82 hospitals of various sizes (Appendix 2). A total of 118 people attended the meetings. The majority of the participants were from hospital departments of education or nursing inservice.

FINDINGS AND DISCUSSION

In July 1975 the survey was sent to 5,770 community, nonfederal, short-term general hospitals. Of these, 4,669 hospitals, or 80.9 percent, responded. Of those responding, 2,680 stated that one or more programs had written goals and objectives. Thus, the universe for the analysis as it relates to the survey definition of inpatient education is 2,680 hospitals. In addition, information was gathered from the 11 group discussion meetings with staff from 82 hospitals to support and clarify survey findings.

Part 1. Overall Hospital Programs

Policy

A policy is usually seen as a guide for action. Barbara J. Stevens, in her book, *The Nurse as an Executive*, defines a policy as "a rule for human conduct formulated with a particular intention in mind."[3] A policy should describe the total scope of the hospital's or a division of the hospital's responsibility. Thus, a policy operationalizes goals and objectives, designating the boundaries within which these goals will be achieved.

Of the total number of hospital respondents, 329 (12.7%) had a written policy regarding inpatient education. Further exploration with hospital personnel about their responses showed the following:

- Some policies were rules by which the department and/or committee responsible for patient education were guided.
- Other policies were *general* hospital policies that were patient education guides for all hospital staff.

When asked why their hospital had or did not have a policy for patient education, the following responses were made:

Yes
- To emphasize to staff that patient education is a priority and a patient's right
- To show administrative support
- To show the need for budgeted funds
- To use as guides for implementation in different parts of the hospital, that is, outpatient department and inpatient areas
- To outline the hospital's responsibility to patient education
- To define to staff that patient education is integral to care and that they have some responsibility for patient education
- To facilitate a uniform, structured program that can be evaluated

No
- Patient education is already an accepted philosophy of nursing service
- We haven't felt the need
- It is an unwritten policy
- It is a part of the policy for audit
- We are using informal guides while the program is developing before writing a formal policy

Policy Committees

Committees can be used to recommend and oversee policies related to patient education. Multidisciplinary membership reflects a commitment to patient education as an appropriate function of all direct care providers. As a multidisciplinary/multidepartmental activity, patient education requires:

- Multiple input for goal attainment
- Multiple and interdepartmental management support for implementation

Appropriate functions of a patient education policy committee include:

- Determining and recommending guides (policies) by which patient education will be achieved

[3] Stevens, Barbara J. The Nurse as an Executive. Wakefield, Mass. Contemporary Publishing Co., 1975. p. 110.

- Determining patient education priorities
- Approving patient education programs for specific patient populations
- Reviewing ongoing patient education activities

In determining whether or not a new committee is needed to help implement patient education at the policy level, the administrator/manager should ask the following questions:

- Can existing committees be used to reach patient education goals?
- If a new committee is to be organized, how will it interface with existing committees and departments?

Of the hospital respondents having at least one program, 461 (17.2%) responded that they had a policy-setting committee (Appendix 3). Of these, a small number (38 or 8.2%) indicated that this was the executive committee. Relatively few (88 or 19.1%) indicated a patient-education committee (PEC), that is, a committee primarily or solely concerned with patient education. More (139 or 30.2%) placed this responsibility in the somewhat generalized patient care committee. However, the category most frequently cited (196 or 42.5%) was "other", within which 180 of the 196 hospitals specified their committee title. Examination of the 180 "other" committee titles discloses that they could be subgrouped into education versus administration-oriented committee titles. Titles were further separated by clinical department and patient care-oriented committee (COC) (Appendixes 4 and 5).

Education-oriented committees (EOC) were defined as those with titles that suggest education, either for patients or for staff. Administration-oriented committees (AOC) were defined as those with titles suggesting a multipurpose nature or specifying an administrative/clinical function. There were more administrative (96) than education (84) citations in the "other" group. The three most common "other" committee titles cited were nursing audit committee (AOC), education committee (EOC), and in-service education committee (EOC). Combining all data for this question, it can be seen that while the policy-setting function was not necessarily found in a committee specifically for patient education, it most frequently was placed in an education-related committee (172 or 37.3%). Placement in a care-oriented committee was also prevalent (157 or 34.1%).

Titles in the "other" category were also analyzed for membership, to determine single versus joint/multiple discipline input into policy decisions (Appendix 6). In the "other" category alone, it was found that 126 of 180 or 70.0 percent, of committees were those that probably had joint or multidisciplinary membership. In most cases patient care, executive, and patient education committees have a multidisciplinary membership composition. Therefore, the total response indicates the use of a multidisciplinary committee for patient education policy setting in a majority of cases (391 of 461 or 84.8%).

Committee Membership

For all committees cited by respondents, nurses are the most likely personnel to be found on patient education policy setting committees (93.7%), followed by physicians (71.8%), and administrators (57.3%) (Appendixes 7 and 8). Consumers and auxilians/volunteers were more likely to be members of committees specifically designated for patient education.

When hospital staff at the group discussion meetings were asked why they did or did not have a committee to determine general policy for all patient education programs, the answers reflected that hospitals are just beginning to plan and coordinate patient education activities from a "total hospital" perspective. Instead, individual programs designed for specific patient populations within a hospital are currently predominant. In general, rather than policy committees, participants tended to use ad hoc committees to design programs for disease-specific populations. An established committee, the director of education, and/or the administrator and/or director of nursing would then approve the program design for the specific population.

Education Activity Coordination – Department

The responses to the questions about the coordination of inpatient education activities were analyzed for information to identify:

- The number of hospitals that have recognized the need for patient education activities to be coordinated and have designated a line responsibility for them;
- Where hospital management is currently placing the coordinating responsibility; and
- Whether bed size is a significant variable in the designation of responsibility for patient education.

Appendix 9 summarizes the survey responses about patient education activity coordination. Of the 2,680 hospitals that have at least one patient education program, 1,218 (45.5%) listed a department responsible for coordinating inpatient education activities: 701 (57.6%) named nursing as the responsible department, and 298 (24.5%) listed the education department. Of the 178 (17.9%) respondents that checked "other", 108 specified the name of the department (Appendix 10). The "other" titles listed were usually education-related departments (70.4%), and the majority of these were related to in-service education or staff development. Joint departments were cited infrequently, accounting for 10.2 percent of "other" responses and less than 1 percent of all hospitals indicating departmental responsibility for patient education coordination. However, in these cases, the nursing or the education department comprised one (or both) of the listed departments.

In summary, less than half of the respondents with patient education programs cited specific line responsibility for coordination. Where a line designation is made, the department of nursing is responsible in the majority of cases; for the total population it is cited more than twice as often as an education or education-related department, the second ranked department type cited. This is generally the case regardless of bed size (Appendix 9). Neither clinical departments other than nursing or administrative departments (administration, public relations, personnel, and "other" administrative-oriented departments) were likely to be responsible for coordination of the patient education function.

At the hospital discussion meetings, participants explained the rationale for choosing the department in which patient education coordination responsibilities were placed:

Nursing Department

- Interest began in nursing
- Qualified personnel are in nursing, we have an RN with a master's in teaching and rehabilitation
- All teaching occurs on the nursing unit
- RNs were already doing teaching and performing care
- Director of nursing wanted diabetic classes implemented
- Nursing service is basically responsible for everything happening to a patient during hospitalization

Education Department

- It is an education function
- Education is a "neutral department"
- Education staff have "flexible" time
- Department head proposed program
- Patient education was felt to be related to staff education
- Educational skills of staff are needed

Administrative Department

- It is easier to gain cooperation of clinical departments
- Grant mandated that administrative department have responsibility

In many cases, it can be seen that the placement of the patient education responsibility in the nursing department is predictable, given the resources at hand. In most hospitals, for example, nursing personnel comprise the largest percentage of direct care staff. Too, nursing staff frequently play a significant role in coordinating overall patient care and may be responsible for seeing that orders in areas of patient care such as dietary or physical therapy are completed. In hospitals with scarce ancillary service resources, nursing may carry out such orders. (There is a direct relationship between bedsize and the number of non-nursing service resources.) In these cases, it is not unusual for the majority of patient education to be done by the nursing staff in conjunction with the physician. In short, the designation of this function to the nursing department can be justified on several counts.

However, in meeting with staff from hospitals where a clinical department was responsible for patient education, it was noted that many had only looked at patient education coordination as it occurred within that department. Assessment of other departments' patient education activity was not carried out, and no collaborating mechanisms existed.

A nonclinical department also is not likely to coordinate patient education activities effectively without the support of clinical departments. This was identified at the group discussion meetings by those who represented hospitals with an education department as the responsible agent. If that department did not have good rapport with other departments, especially with the nursing department (and particularly with nursing management, down to the head nurse level), its patient education efforts were vocalized as failures.

A fundamental requisite for the effective coordination of patient education by any department is administrative support. Such support is demonstrated through budget allocation for the coordination function, staff assistance when warranted, and maintenance of an evaluation and recognition system for patient education activities of staff.

Educational Activity Coordination – Coordinator

Much of the foregoing discussion is pertinent when the patient education responsiblity is held by a coordinator within a department. That is, in order to support integration of the patient education function, the person in a coordinator position must be able to relate to many clinical departments and to clinical support departments, such as medical records, library, and staff development. Consistent with the administrative support identified above for this function, the coordinator should possess the abilities to generate and control a budget and supervise assistants, and, when appropriate, to provide input into the staff evaluation mechanism.

Of those hospitals designating a "responsible" department, 1,080 (84.6%) also identified a person in the department responsible for patient education. Only 143 (13.9%) were designated as full-time patient education coordinators. Of these, 73 listed specific titles. Closer examination of these titles indicated that it was questionable whether some responses (for example, in-service education director) actually fit the criteria of a full-time person appointed solely for coordination of patient education activities (Appendix 11). It was found that the larger the hospital in bed size, the more likely the title was primarily oriented toward patient education coordination; furthermore, the larger the bed size, the greater the likelihood of inclusion of the term "coordinator" in the title.

In order to ascertain the functions of the people occupying some of these positions, 21 job descriptions were obtained from staff in the discussion groups. Eight of the positions were specifically designated for patient education. Five were positions in which patient education is one of the job responsibilities (Appendix 12).

From the information about the desciplines in these positions as well as from those who attended the group discussion meetings, it seems that the majority of persons designated as patient education coordinators have training responsibilities for hospital staff and are in the department of education or nursing education. Most have credentials in nursing.

Daniel S. Schechter, in *Agenda for Continuing Education* (1972),[4] reports on a national survey of hospital-based educators. This study provides a profile of 536 hospital-based trainers, members of the American Society for Health Manpower, Education, and Training. The following salient points were made:

> Only about one-tenth of the respondents had earned teaching certificates; most of the group had credentials in nursing. Thirty-one percent of the nursing department and 16 percent of the education department respondents reported having no training experience prior to their current positions. As a group, the survey respondents showed considerable experience in the health field but the majority (65%) had been in their current positions for less than 3 years. Twenty-eight percent of the respondents in education departments and 15 percent of those in nursing departments had held their current position less than 1 year.[4]

[4] Schechter, Daniel S. Agenda for Continuing Education. Chicago, Ill. American Hospital Association, 1972.

Trainers perceive their own most urgent continuing education need to be learning how to evaluate training programs carried out within their hospitals. They also need closely related instruction in how to measure training costs. They are amply supplied with educational hardware and are interested in using new educational methods and technology, but they need assistance in evaluating software from outside sources and in creating their own training materials. Nearly half of the respondents would like to learn more about assessing training needs. It also appears that trainers are unfamiliar with or inexperienced in the use of techniques employing objective data for reliable determination of needs.[4]

It appears that hospital-based trainers recognize a need for educational programs for public served by hospitals and they believe that patient and community health education, as well as continuing education for hospital personnel, should be part of their responsibilities. Although 77 percent of all respondents predicted increasing need for programs of patient education, only 30 percent reported ever having planned or conducted patient education programs. Similarly, although 68 percent predicted increasing need for programs of community health education, only 23 percent reported ever having planned or conducted such programs.[4]

Support for patient education activities is given to hospital staff on patient units in several different ways. The following means of support were designated at the meetings.

Staff education about patient education	*Persons responsible*	*Method*
• Relating to disease-specific populations	• Clinical specialist	• Role play
	• Education staff with primary responsibility for disease specific area	• Lecture
	• Outside consultants	
• Relating to education skills	• Education staff	• Role play
	• Outside consultants	• Case studies
Participation in actual education of patient		
	• Specific person designated	
	• Clinical specialist • Enterostomal therapist • Diabetic nurse • Cardiac nurse • Discharge planners • Education staff person with specific areas of responsibility	• One-to-one sessions and/or classes
Provision of materials and media		
	• Librarian • Education staff • Media specialist	

The patient education coordinator may have support responsibility for a disease-specific area (for example, diabetes) or responsibility for coordinating the activities of others who

4. Schechter, Daniel S. Agenda for Continuing Education. Chicago, Ill. American Hospital Association, 1972

have disease-specific areas and who in turn coordinate patient education activities for that specific disease or hospital unit.

The coordinator's ability to give support to staff is influenced by the resources in the department responsible for staff education. Participants in the group meetings discussed the education function and its relationship to patient education. On the basis of information received, the following summaries of current staff and structural resources for education-related functions were developed:

Hospital bed size*	Resources
30-99	The director and/or the assistant director of nursing is responsible for staff and patient education.
100-199	A part-time or full-time instructor has staff education functions. Some instructors have an added responsibility for diabetic and/or ostomy teaching. One hospital has a discharge planner with added responsibility for diabetes and colostomy teaching.
200-299	Two or three in-service instructors are responsible for staff education. Some have part-time staff for diabetes, ostomy, and/or cardiac patients. Some use nurse practitioners or clinical nurse specialists. Some have staff with the title of patient education coordinator.
300-399	Considerable variation in staff education management was reported. Some hospitals indicate titles of coordinator of patient education under nursing in-service. Others have an education department with a patient educator. Several list clinical nurse specialists. One has a continuity-of-care department with staff education and patient teaching responsibilities.
400-499	These hospitals have a department of education with 4 to 12 staff members. When staffed with more than 4, departments may include nurse specialists, part-time patient teachers, librarians, and/or media specialists. One hospital reports a health education department.
500 or more	These hospitals have a department of education (one has a department of personnel services and human resource development) with 9 to 19 staff members. Staff may include instructor, TV technician, librarian, part-time diabetes and ostomy instructors, and discharge planners. Activities are coordinated with several "types" of clinical specialists.

Outside Consultants

Of the 2,680 respondents with at least one organized patient education program, 897 (33.5%) reported the use of outside consultants to help plan their inpatient education programs. Of these, 599 (20.9%) identified the institutions and organizations employed for this purpose. Many hospitals listed more than one consultant. The total number of consultants cited was 1,324.

Appendix 13 provides a detailed summary of findings. Consultants were categorized into voluntary and nonvoluntary agencies. The latter category was further divided into private, governmental, academic, inpatient care delivery, commercial organizations, and individual specialists. The smallest hospitals were the most frequent users of outside consultants; 24.9 percent of the hospitals in this bedsize (6–199) cited consultant use. Further, they accounted for 57.6 percent of all consultants cited. Nonvoluntary agencies were the most frequently cited type of consultant (58.2%).

Dollar Sources

Of the 2,680 hospitals with at least one program, 1,572 (58.7%) stated that revenues generated by daily rates were dollar sources for inpatient education. Two hundred (7.5%) listed separate billing, and 415 (15.5%) listed gifts or grants (Appendix 14).

* It seems as hospitals increase in size, there are a greater number of "in-house" education services and resources available for patient education.

Of those who billed separately, 99 (49.5%) billed for educational materials, 8. (42.5%) for group classes, 64 (32.7%) for services performed by some other than staff on the unit, and 30 (15%) stated "other". Of those listing "other," 27 (90.0%) provided a further explanation (Table 1).

Table 1. "Other" Separately-Billed Patient Education Items/Services

Items/Services	No.	%
• Class or course participation	7	25.9
• Individualized services (includes 1:1 instruction or other specific service)	9	33.3
• Materials	7	25.9
• Department Fees	4	14.9
Total	27	

When all separate billing item responses were considered, (n=332, since several hospitals listed more than one response), it was found that when separate billing for education is made, hospitals are twice as likely to bill for services provided as for materials (Table 2).

Table 2. Separate Billing Items for Patient Education

Services		Materials		Other Items	
• Group classes	85	• Educational materials	99	• Department Fees	4
• Services by other than unit staff	64	• "Other" materials	7	• "Other", no explanation	3
		Total Materials	106 (31.9%)	Total Other	7 (2.1%)
• Other services					
Classes/ courses	7				
Individual	9				
Total Services	219 (66.0%)				

Of the 2,680 hospitals, 694 (25.9%) reported funds budgeted for patient education. By cross tabulation it was found that of the 694, 423 (61.0%) stated they used only revenues from daily rates for their funding sources, 5 (0.7%) used only separate billing and 29 (4.2%) used only gifts and grants, 128 (18.4%) used both daily rates and gifts or grants (Appendix 15).

In the follow-up discussions with hospital staff, participants often stated that budgeting specifically for patient education was unnecessary because it was seen as integral to the responsibility of staff and/or departments that already had budgets. Many stated that they use department equipment and as much free patient education material as possible. In this case, a separate budget for patient education was not considered necessary.

Where coordinating responsibilities were designated to a department of education (either general or a part of), both individual staff accountability for education and staff knowledge of the budgeting process were likely to increase directly with the number of staff in that department.

Part 2. Specific Hospital Programs

It was anticipated that a large number of education programs for specific patient populations exists among the hospitals surveyed. A sample of individual programs was obtained from participants at the hospital group discussion meetings (Appendix 16 – staff/time structural analysis of some of these programs).

The survey was not intended to compile descriptions of each population specific program. However, this section of the survey does help to determine:

- The number and types of patient education programs for specific patient populations
- The hospital personnel involved in inpatient education programs
- The mechanisms and methods being used to assess, plan, initiate, implement, document, and evaluate programs

Discussions in this section are arranged in the order of the survey questions.

Frequency of Programs

The types of adult patient education programs are listed in order of frequency in Table 3.

Table 3. Most Frequently Reported Specific, Adult Patient Education Programs in Hospitals.

Type of Program	No. of Hospitals Reporting
Diabetes	2,097
Nutrition	1,453
Prenatal	1,426
Ostomy	1,337
Mastectomy	1,275
Heart Attack	1,263
Postnatal	1,200
Preoperative	1,186
Respiratory	906
Postoperative	894

The types of pediatric patient education programs in order of frequency are listed in Table 4.

Table 4. Most Frequently Reported Specific, Pediatric Patient Education Programs in Hospitals.

Type of Program	No. of Hospitals Reporting
Diabetes	960
Nutrition	537
Orientation to Hospital	485
Preoperative	484
Postoperative	348

Staff Involved

The staff members most frequently involved in planning and teaching were nurses. More physicians were listed as being involved in planning (1,557 or 58.1%) than in inpatient teaching (1,150 or 42.9%). Community support groups (for example, Alcoholics Anonymous, ostomy clubs) were listed by 1,151 hospitals (42.9%) as teachers in the patient education programs.

The information obtained about groups involved in patient education programs is summarized in Table 5.

Table 5. Groups Involved in Planning and Teaching in Patient Education Programs in Hospitals.

Professional Group	Planning (No. of Hospitals Reporting)	Teaching (No. of Hospitals Reporting)
Registered nurses on inpatient units	2,181	2,503
Dietitians/nutritionists	2,002	2,260
Licensed practical nurses on unit	899	1,569
Nursing in-service staff	1,830	1,558
Physical therapists	1,284	1,507
Respiratory therapists	1,065	1,269
Physicians	1,557	1,150
Community support groups (AA, ostomy clubs, and so forth)	858	1,151

Initial Assessment of Patient and/or Family

In the majority of cases (48.1%), initial assessment of patient education needs was obtained as part of the history taken by health personnel. A large group, 724 (18.5%) held separate interviews for patient education. No initial assessment was done in 381 (9.7%) cases.

Initiation of Program

The most frequently cited methods of initiation of individual patient education programs were by physician order (39.4%) and by action of another health professional (38.1%). In 18.9 percent of responses, a standing order was used.

Planning for Individualized Learning

Nursing care conferences (58.5%) or patient care conferences between nurses and physicians (45.3%) were most often cited as the mechanisms for formal planning of individual patient teaching. Multidisciplinary team conferences for patient care (24.7%) or specifically for patient education (8.8%) were less prevalent.

Target Population

According to the response received, the primary education target group was patients in conjunction with family members (62.4%). Thus, extension of patient education to include the family predominated. Only 228 hospitals reported provision of education to the patient alone (31.8%). In relatively few cases (5.7%) were education programs focused exclusively toward family and friends.

Program Methodology

Several methodologies are used for patient education programs. Although one-to-one teaching was most prevalent (2,579 or 96.2%), in 839 cases (31.3%) small groups (10 or fewer members) were used. Large groups (more than 10) were used less frequently 317 (11.8%). Other persons with the same health problem were often involved in patient education (1,170-43.7%).

Use of volunteers (not someone with a similar health problem) was cited in 236 (8.8%) cases.

A wide range of media and materials are available for use in patient education, and hospitals reported use of both externally and internally produced materials. The most commonly used materials were brochures, booklets, and pamphlets, followed by filmstrips, films, and flipcharts. Video programs (611 hospitals) and telephone dial access (282 hospitals) are also being used in patient education. The number of hospitals using video and dial access are listed by regional and state groups in Appendix 17.

Many sources of patient education programs were cited throughout the hospital discussion meetings. The number of different sources for common disease entities reported were: Diabetes – 23, Respiratory – 19, Heart – 17, Ostomy – 11, and Arthritis – 9.

Patient Education Centers

A total of 253 hospitals responded that they have a patient education center for patients and families to come for learning. Follow-up telephone calls were made to the 253 hospitals to find out more about their centers. Most of the persons contacted stated that patients and families were taken to the nursing in-service education office if they needed "special" instruction. However, 36 of the respondents identified the use of areas specifically designated for patient education activities. These patient education centers are discussed at length in Appendix 18. A summary description of these centers is presented here in terms of their most commonly cited characteristics:

1. *Location* Most centers use a separate classroom, some use a renovated patient-care room, and some (52.7%) utilize multipurpose areas.
2. *Staff* Centers are most likely staffed by nurses only (37.5%) or by a combination of staff of different disciplines (37.5%).
3. *Consumers* In all cases inpatients were specified as users of the center; in addition, families (31%), community (13.8%), and staff (17.2%) used the center on a less frequently cited basis. Services were extended to outpatients in 17.2 percent of the cases. The patient problem most commonly dealt with at the centers was diabetes (46%), although 16 percent sponsored prenatal education and 12 percent had coronary programs.
4. *Mode of entry* The most common way in which patients were introduced to the center was through physician referral (25.9%) or through information from non-physician staff (25.9%). The patient was given the option to use the center in 48.1 percent of the cases and referred to the center in 51.9 percent of the cases.
5. *Materials used* Respondents mentioned 18 types of materials used to aid learning. The most commonly used tools were films (used by 46.2%), pamphlets (38.5%), audiovisual materials (30.8%), and videotapes (used by 23.1%).
   The average number of types of materials used per learning center was 2.5.
6. *Activity* The most frequent center activity was holding classes (62.5%), providing one-to-one interaction, and providing education materials to patients.
7. *Hours open* Only a few respondents (19.4%) specified the hours the center is open. Of these, these was an equal likelihood that the center functioned in one of the following ways: (1) on a 24-hour basis as an inpatient unit, (2) on a 24-hour basis as a separate entity, or (3) on a limited (specified hours) basis.

Of the 36 centers, six had a room designated solely as a patient education center. These six also identified the use of more than two types of media, including at least one audiovisual. Two of the six designated the use of librarians. One hospital, although its space is shared by staff for in-service education, has a full-time librarian.

Documentation

Although documentation of patient education activities is often stated as a problem, 1,809 (67.5%) hospitals responded that specific provision had been made for documentation somewhere on the medical record. Most listed documentation on nursing progress notes 1,442 (53.8%). However, 523 (19.5%) listed a separate sheet for patient education, and 570 (21.3%) listed documentation on the discharge planning sheet. A few hospitals, 267 (10%), report that they document on integrated progress notes.

Audit

In 1,842 cases (68.7%) patient education outcomes as part of audit were listed as a component of nursing audit. Patient education outcomes are not included as part of audit in 708 hospital respondents.

Posthospitalization

The data disclose that 1,446 (54%) hospitals send information about a patient's educational experience to nursing homes, 1,132 (42.2%) send such information to Visiting Nurses'

Associations, only 264 (9.9%) send it to public health departments, and 850 (31.7%) hospitals indicated they they send information to outpatient departments (approximately 934 community hospitals have outpatient services). Also 643 (24%) hospitals send information to physicians, and 431 (16.1%) send information to patients.

Evaluation

The evaluation section of the survey was divided iinto three categories. First, focus was placed on the methods used by hospitals to assess the impact of inpatient education on the patient. Second, the time at which evaluation occured was explored. Third, focus was placed on methods used to evaluate the program itself. (In addition to the above methods, audit for the documentation of defined outcomes should also be viewed as a form of evaluation.)

By combining scores of "some" and "all," instances of evaluation for a total number of hospitals carrying out evaluation for each designated form of evaluation on the survey can be obtained.

In examining hospitals with programs that assess impact of education on the patient, the largest number, 2,132 (79.6%) use observation of task performance and the smallest number, 585 (21.8%) use the interview of the attending physician.

In 2,372 (88.5%) cases, evaluation of the patient occurred prior to discharge. A postdischarge mailed survey was indicated by 251 (9.4%) of the respondants.

In terms of methods used to evaluate the program itself, the least complex forms of evaluation were listed most often. That is, 1,253 (46.8%) listed interview of staff, and 1,191 (44.4%) kept records of the number of patients and families given the program. Statistical comparisons of patient readmission rates and analysis of inpatient education referrals per total admissions were the least used methods of evaluation, cited by 248 (9.3%) and 155 (5.8%) hospitals, respectively. Follow-up phone calls were made to the 248 hospitals listing statistical comparison of hospital readmission rates. Although many answered that they had patient education programs, very few had done statistical analysis to support the effect of patient education in reducing readmission. As a result of the telephone calls, 14 written responses were sent to American Hospital Association. Of those responses, four supplied the information requested (several reported nonspecific readmission rates and intentions to do statistical analysis in the future).

Of the four hospitals that provided statistical information:

- All were concerned with diabetic programs (one also had a coronary program).
- Three used the readmission rate as an independent variable; each of these showed a significant decrease in readmission rate, 0.57 percent to 15.6 percent. (Use of a random group for comparison was included in only one study).
- One study using measurable patient variables (blood sugar level and weight) on an outpatient sample showed that more patients maintained their blood sugar level and weight than did not. However, there was no control group for comparison.

Variations in Implementation of Specific Patient Education Programs

To supplement the survey, staff reviewed documented protocols of approximately 225 individual patient education programs from the 82 hospitals involved in the group discussion meetings. This review was undertaken to obtain some perspective about program implementation at the specific patient population level.

One facet of the program review involved analysis of the utilization of hospital staff and time scheduled for patient education for several common disease specific programs (Appendix 16).

The following observations were made:

- A wide range of health care providers were recognized as responsible for patient education.
- The nursing staff was most frequently identified as the responsible agent and provider of education.
- Where teaching was indicated on an informal or ongoing basis, that is, to occur as integrated with other treatment tasks, all direct-care-givers were more likely to be identified as participant teachers.

- Where teaching occurred in a formalized or scheduled manner (classes), a specified health educator was likely to be responsible for the education program.
- Where the use of a specific "health educator" was identified, the task was just as likely to be added, on a rotating or consistent basis, to the responsibilities of individual staff members as to be developed into a separate job position.
- Staff accountability mechanisms specifically for patient education responsibilities were rarely identified.
- The programs reviewed were primarily developed to address specific disease processes and health conditions. Trends found regarding the education time used for each of the specific disease/condition focuses are summarized as follows for some of the programs.

Disease Condition	*Trends in Use of Educational Time*
Hypertension	Series of scheduled classes
Prenatal/postnatal	Series of scheduled classes
Stroke	Patient: ongoing (integrated into care/rehabilitation process) Family: series of scheduled classes
Mastectomy	Ongoing teaching (i.e., given with individual care)
Ostomy	Ongoing teaching
Chronic obstructive pulmonary disease	Ongoing teaching
Myocardial infarction	Combination of ongoing teaching and series of scheduled classes
Diabetes	Combination of ongoing teaching and series of scheduled classes
Preoperative	Combination of one class and one individual session

- The need for patient skill-training (for example, medication administration, equipment use and application, exercise) increases the need for ongoing and one-to-one teaching.
- Classes are usually conducted in a regularly repeating series. The average length of sessions is 1 to 2 hours, and the average frequency is one to two sessions per week.
- Even when classes are identified as the main vehicle for presenting educational content, individual reinforcement by direct-care staff on an "as needed" basis is usually specified.

Part 3. Regional and State Variations

Information from the survey provided preliminary assessment of current inpatient education activities within states and regions (by U. S. Census Divisions) listed below:

1. New England	**5. East South Central**	**9. Pacific**
Connecticut	Alabama	Alaska
Maine	Kentucky	California
Massachusetts	Mississippi	Hawaii
New Hampshire	Tennessee	Oregon
Rhode Island	**6. West North Central**	Washington
Vermont	Iowa	**U.S.-Associated Areas**
2. Middle Atlantic	Kansas	American Samoa
New Jersey	Minnesota	Canal Zone
New York	Missouri	Guam
Pennsylvania	Nebraska	Marshall Islands
3. South Atlantic	North Dakota	Puerto Rico
Delaware	South Dakota	Virgin Islands
District of Columbia	**7. West South Central**	
Florida	Arkansas	
Georgia	Louisiana	
Maryland	Oklahoma	
North Carolina	Texas	
South Carolina	**8. Mountain**	
Virginia	Arizona	
West Virginia	Colorado	
4. East North Central	Idaho	
Illinois	Montana	
Indiana	Nevada	
Michigan	New Mexico	
Ohio	Utah	
Wisconsin	Wyoming	

Distribution of Programs and Administrative Variables

Information about several patient education variables, by state and by region, can be found in Appendix 19. (Appendix 20 for definition of variables.) For example, presented in Appendix 19 are the total number of responding hospitals and the total number of these hospitals with organized patient education by state and region. Although variations exist by state, certain regions fall significantly below the national average (57.4%) of hospitals with organized programs. Specifically, regions 5 and 7 contain no states that exceed the national average, and region 8 contains only two states above it. Using a regional perspective assists in identifying broad areas in which patient education organization efforts can be undertaken.

Statewide use of administrative variables can also be identified from the information in Appendix 19. For example, it can be noted that 100 percent of the hospitals in Vermont and 93.8 percent in New Hampshire with organized programs had patient education outcomes as part of audit.

The data in Appendixes 21 and 22 provide a state and regional perspective of hospitals with organized patient education programs with a person designated as responsible. It seems logical that if hospitals have designated a person to be responsible for coordinating patient education activities, they have recognized a need to organize their patient education activi-

ties within the hospital. For example, although the number of Montana hospitals that reported organized programs was considerably less than the national average (13 or 28.9%), Montana exceeded the national average in having a person responsible to coordinate programs. The same occurs in New Mexico, Georgia, Colorado, and Maine. In comparison, hospitals in Vermont, Massachusetts, Iowa, New Jersey, Michigan, Indiana, Maryland, Delaware, Wisconsin, Pennsylvania, Idaho, and Utah surpassed the U. S. average of hospitals with organized programs, and these hospitals were also more likely to designate a responsible person.

Structure of Current Patient Education Programs

Six administrative variables – policy, committee, person, budget, audit, and evaluation – were organized into 16 combinations to identify any trends related to how hospitals within states were structuring their programs (Appendix 23). Although the 16 combinations included all but 221 of the 1,030 hospitals listing a person responsible, only 823 hospitals were included in all combinations. (By adding audit only to the combinations, 593 hospitals were added to the "combination sample" (Appendix 24).

Appendixes 24 and 25 are intended to show whether the presence of certain of the administrative variables related to the number of organized programs listed by hospitals. Although the number of hospitals with less than four administrative components is greater, the majority of hospitals with four or more administrative elements are more likely to have more than 10 programs. In comparison, the majority of hospitals falling into categories with only one or two administrative components listed less than 7 programs.

Appendix 26 shows the number of hospitals with all six variables or five variables (except policy or budget). All six variables were listed by 47 hospitals, all variables except policy, were listed by 33, and all variables except budget were listed by 27. California, Minnesota, and Pennsylvania had more than 6 hospitals in the above categories.

Hospitals of fewer than 200 beds were more likely to list only one variable – the responsible person. Hospitals of more than 200 beds were more likely to list all 6 variables (Appendix 29).

Data from Appendixes 23 through 27 suggest that hospitals are just beginning to implement patient education within a defined administrative structure for the total hospital.

Variation by Bed Size

Throughout the report, data have been analyzed to show how bed size relates to number and type of patient education activities. For emphasis, hospitals with low and high numbers of patient education programs are grouped according to bedsize in Appendix 28. In this way the tendency for hospitals (by percent) to have more patient education programs as they increase in bedsize becomes evident. This could be attributed to the increase in diversity of diagnoses that tend to be found in larger hospitals and the increase in available *in-house* resources to hospitals.

In order to determine whether bed size made a difference in administrative components included in the design of the patient education program, the percentage of responses for each variable by bed size were rank ordered in Appendix 29.

The greatest difference occurred in the areas of budget, department responsible, and inpatient coordinator. In the budget category, the percent of hospitals having a budget increased directly with bed size. In the inpatient coordinator category, hospitals with 500 or more beds were least likely to have a coordinator; those with bed sizes of 100 to 199 and 200 to 299 were most likely to have a coordinator. The same was true in the category of responsible department.

Hospitals of 300 to 399 beds had the highest percent of respondents listing a full-time coordinator. Hospitals of 6 to 99 beds contained the largest percent using outside consultants, and hospitals of 500 or more beds had the lowest percent.

SUMMARY

In view of the perceived need for management of the patient education function, a study was undertaken by the American Hospital Association, using as the study instrument *The Hospital Inpatient Education Survey*. The study goal was to obtain a current assessment of organized patient education programs in hospitals in order to guide the subsequent development of effective inpatient education programs. The survey sought information about overall organizational structures relating to patient education and about specific education programs. In July 1975, surveys were sent to 5,770 U. S. community hospitals. An 80.9 percent response was obtained. From this response, 2,680 hospitals indicated at least 1 inpatient education program by survey criteria. This universe was used for all subsequent data analysis. To corroborate findings, eleven meetings across the country were held with 82 hospitals attending. At these meetings, clarification of survey data was made and documents of 225 specific inpatient programs were obtained for further analysis. A contract with the Bureau of Health Education funded much of the analyses.

Part 1. – Overall Hospital Programs

The organization variables as they refer to patient education management selected for study were:

- policy statements
- use and type of policy-setting committees
- committee membership
- type of line responsibility for activity coordination
  - by department
  - by person responsible
- use of outside consultants
- dollar sources
- budget allocation

An overall patient education policy was cited by 12.7 percent. Rationale offered for developing a policy statement was that a policy emphasized the hospital support for and staff commitment to patient education. Policy was also used as a guide to insure a consistent and measurable approach to the task.

A committee to generate and monitor patient education policy was used by 17.2 percent of the respondents. Multidisciplinary membership was helpful in encouraging health team commitment to and communication about patient education. Nurses were most likely members on patient education policy-setting committees (93.7%), as were physicians (71.8%) and administrators (57.3%). Other clinicians were also cited as likely members.

The infrequent use of policy and committee structures found in the survey was reflected in discussions at the group meetings. Participants related that attention is just beginning to be given to planning patient education from a total organizational perspective. Usually, individual specific programs emanate from within the hospital structure; ad hoc committees are used to plan at this level.

Responsibility for coordination of patient education activities was placed in a department by 45.5 percent of respondents. Regardless of bed size, nursing was the most frequent department cited. The nursing department was more than twice as likely to be cited as the second ranked department, i.e., education. Caution was raised about placing the responsibility within a single clinical department, namely, that ways to collaborate patient education activities with other departments were not developed.

Of those citing a department with line responsibility for patient education activities, 84.6 percent reported a person/position within the department responsible for the coordinating

function. Only 13.9 percent were full-time patient education coordinators. The majority have staff development roles as well. Most persons responsible to coordinate patient education activities were registered nurses and resided within the department of education or nursing education. The likelihood of having specialized staff and resources allocated to patient education increased with hospital bed size. The coordinator's capability to provide staff support for patient education is influenced by the resources of the department responsible for staff education.

Approximately one-third of the respondents used outside consultants for patient education activities. Smaller hospitals, i.e., bed size 6–199, were the predominant users. Voluntary agencies accounted for 41.8 percent of the consultants. The remaining 58.2 percent were classified as non-voluntary agencies and included, in order of cited frequency, the following categories of agencies: private service agencies, persons/specialists, hospitals/medical centers, schools, government agencies, and commercial companies.

The cost of patient education was a part of per diem rates in 18.7 percent of respondents. Less frequently cited dollar sources for patient education were gifts and grants (15.5%) and separate billing (7.5%). In cases of separate billing, charges were primarily made for services provided. Only one-fourth of the respondents indicated patient education as a budget item.

Part 2.- Specific Hospital Programs

Information about specific patient education programs was obtained from the second part of the survey. Data included:

- the number and categories of programs for specific patient populations;
- the hospital personnel involved in specific programs; and,
- specific program planning, implementation, documentation, and evaluation methods.

The most frequently reported adult and pediatric specific programs were rank ordered. For both populations, diabetes programs were most frequently cited. The staff most frequently involved in teaching and planning were nurses. More MDs were listed as planners (58.1%) than teachers (42.9%). Community support groups were identified as teachers in 42.9 percent of responses.

An initial assessment of patient need for education was conducted by approximately 90 percent of respondents. Although the assessment information was generally obtained as a part of an overall patient history, separate patient education interviews were conducted by 18.5 percent of the respondents.

Patients were most frequently initiated into an education program through the written order of a physician (39.4%) or other professional care givers (18.5%). Standing orders accounted for an additional 18.9 percent of initiation mechanisms.

Use of staff conferences was most often cited as the means to formally plan an individual patient's education program. Use of nursing and nurse-physician conferences predominated over multidisciplinary conferences.

The target population for patient education programs included *both* the patient and family in a majority of cases (62.4%). Programs designed specifically for families of patients were identified by 5.7 percent of the respondents.

Programs were most often implemented on an individual, one-to-one basis (96.2%), although groups were also frequently used.

A person with a similar type health problem or condition was utilized to assist in the teaching process by 43.7 percent of respondents. Volunteers (not someone with the same health problem) were involved in teaching by 8.8 percent.

A wide assortment of materials were utilized to assist in the education process. Most commonly cited were printed materials (brochures, booklets, etc.), although there was significant use of audiovisual media and telephone dial access systems.

Thirty-six respondents (by telephone follow-up) identified the use of patient education centers. These are areas *specifically* designated and equipped to provide health information and materials to patients. Frequently there are staff on hand, clinical or library, to offer assistance. Patients may be self or staff referred. Reading materials, charts, and audiovisual

viewing are available at these centers. Classes and individual instruction may also be conducted.

Provision to document the patient's education experience was made by 67.5 percent of respondents. The use of progress notes (nursing, physician, or generalized) was most often cited, although separate patient education forms and discharge planning records were also used to record patient education. The survey indicated that information about a patient's educational experience was frequently shared with various post-hospital care persons and agencies.

Evaluation survey items were concerned with methods used for patient and program evaluation, as well as the time of patient evaluation. The most predominant method of patient evaluation was staff observation of patient task performance. Consistent with use of this method, patient evaluation most often occurred prior to discharge. Other methods of patient evaluation were also indicated, most occurring after the hospitilization period.

Program evaluation was usually accomplished through staff feedback and through records of the number of program participants. Three respondents supplied statistical studies about the effectiveness of a program in terms of readmission rates; one respondent submitted a post education study of related patient physiological variables. In each case, the effectiveness of the patient education program was substantiated.

A summary of the variations in implementation of specific patient education programs as found in an analysis of 225 documented programs was outlined the report.

Data, by state and by region, of hospital use of selected administrative support variables are displayed in various ways in a series of five appendixes. These variables are: policy, committee, person responsible, audit, and evaluation. The report highlights some of the information available from these data. Noting the variation in use of these variables, both by state and by region, it is suggested that hospitals seem to be just beginning to implement patient education within a defined administrative structure for the total hospital program.

Variation of Bed Size

The number of programs implemented within a hospital was found to vary directly with bed size group. Furthermore, use of administrative variables was found to vary by bed size, especially the variables of budget allocations for patient education as well as designation of a department and coordinator position with responsibility for patient education.

CONCLUSIONS AND RECOMMENDATIONS

Part 1. Overall Hospital Programs

Hospitals differ in where they place the responsibility for patient education and in how they undertake the patient education task. Flexibility is required in making management decisions so that these decisions best fit the needs of the hospital. In addition, management must be aware of what is involved in accomplishing the task and how the decisions they make will affect that task. Thus, we would like to emphasize the following:

1. If a hospital is interested in developing an organized, coordinated program, it must recognize that time must be set aside for assessment and initial planning during the first year. The time needed seems to be approximately 6 - 8 months. Responsibility for initial planning must be designated. Questions to be answered during this phase should include where the responsibility for coordinating patient education activities should ultimately be placed.
2. Wherever the responsibility is housed, the person delegated the responsibility must have the administrative support and skills to gain the cooperation and participation of most hospital departments.
3. In the survey, hospitals define several agencies as consultants. The ability to define and use outside resources is a skill the coordinator should possess.
4. The survey serves to emphasize the importance of involvement and support of nursing management if a successful program is to be realized.
5. A multidepartmental committee is a tool that can be used to gain cooperation and involvement as well as assistance in the planning, development, implementation, and evaluation phases of the program.
6. Once the hospital has defined goals and objectives and has determined priorities, the coordinator will have the information needed to outline a budget and methods to reach those goals.
7. The hospital group discussion meetings showed the importance of the education department. In order for the care-givers in the hospital to carry out their patient education responsibilities they must feel comfortable with the information and skills needed for patient education. Patient education should be part of staff education during orientation as well as continuing education programs.
8. The staff of the hospital must not view the coordinator as the patient educator. She/he must be recognized as the person assisting staff to carry out patient education. The coordinator does not have the time to do all patient education. Staff will "let" the coordinator take responsibility for all patient education if the coordinator role is not clearly defined from the beginning.
9. Staff patient education performance must be evaluated and rewarded if management expects patient education to be accomplished.
10. There is a need for educational programs that will assist those responsible for coordinating patient education to develop skills that will help them to carry out their patient education responsibilities.

Part 2. – Specific Hospital Programs

The survey shows that there are many programs developed for specific patient populations that could be obtained and shared.

Analysis of those that were obtained emphasized the wide range of sophistication of outlines of programs, for example the clearness of objectives as well as the correlation of objectives to methods and evaluation.

Several professional organizations, such as the American Medical Association, American Nurses Association, and the American Society of Hospital Pharmacists, have statements regarding patient education. This stresses the fact that patient education is not the domain of one profession. It is the relationship of the professions in accomplishing effective patient education that must be determined at all levels of the patient education program. The survey shows involvement of many health professions; not all who are involved in planning are involved in teaching and vice versa. It is appropriate that specialists be involved in planning programs and in making decisions about content and methods. However, they need not be the actual patient educator.

The programs most frequently cited are usually those for which (1) a target audience would be found in a special unit, for example, the cardiac unit and obstetric unit or (2) voltary agency involvement is readily available such as mastectomy and ostomy or (3) most physicians accept education as a necessary part of treatment, for example, diabetes. This may give clues as to ingredients for development and implementation of programs: physician support, knowledgeable staff, and available outside resources.

In 1975, the Joint Commission on Hospital Accreditation manual specified guidelines for patient care evaluation. Included was the following statement, "Criteria shall include demonstrated knowledge of the patient concerning health status, level of functioning, and self-care after discharge." Therefore, defining patient education outcomes should be incorporated into the process for defining outcomes for patient care. The people defining the outcomes for a specific population may also be the ones who should define the information, materials, and media to be included in a patient education program in order to meet the patient education outcomes. Documentation of patient education activities and audit for performance of patient education is part of care outcomes.

Patient information that relates to informed consent is a part of a patient education program and should be addressed when determining program content, and discussing documentation.

Another message received from hospitals doing patient education, is that care be taken about generating "new pieces of paper" to implement each program. Staff should look at current tools such as patient history forms, patient care plans, patient progress notes and discharge forms to see how these could be used or changed for staff communication about and/or documentation of patient education activities.

Part 3. – Recommendations

The survey as well as other AHA data suggest the following:

1. The amount of education support and patient education resources available varies from region to region and from state to state.
2. The amount of education support and patient education resources available vary from hospital to hospital.
3. Hospitals are just beginning to coordinate their patient education activities on an overall hospital basis.
4. The majority of persons designated as patient education coordinators have training responsibilities for hospital staff and are in the department of education or nursing education. Most would like to gain skills in the areas of education, management, and evaluation principles.
5. Many programs are already developed for disease specific areas.
6. There are historical data available about patient education programs through documentation about patient education for patient care audit in medical records.

AHA and its Allied Associations and Societies, in conjunction with the Bureau of Health Education and appropriate voluntary and other government agencies, should use the information gained from the survey to develop:

1. Educational programs to assist staff to carry out their patient education activities.
2. Ways to implement those programs particularly in regions with scarce education re-

sources and/or for hospitals with scarce education and/or patient education resources.

3. Examples of programs for specific populations.
4. "People resources" who have experience in coordinating patient education and/or education, management, or evaluation skills.
5. A mechanism to gather information about patient education programs through review of medical records.
6. A patient education materials clearinghouse.

Appendix I.
SURVEY OF HOSPITAL INPATIENT EDUCATION
Conducted By the American Hospital Association

Mailed 5,770
Returned 4,669
Response Rate (80.9%)

Total number of hospitals meeting the definition of one or more programs with written goals and objective – 2,680

We are interested in learning about hospitals' integration of inpatient education into their "overall" hospital goals as well as about programs for specific patient populations. For the purpose of this survey, inpatient education programs are defined as educational activities with *written goals* and *objectives* for the patient and/or family during *inpatient* hospitalization.

The affirmative responses from the 2,680 hospitals are given below:

A. OVERALL HOSPITAL PROGRAM

1a. Does your hospital have a written policy regarding inpatient education?

329 ☐ Yes ☐ No ☐ In planning stages

b. If yes, when was it originally written? _____ (MONTH/YEAR) Last revised? _____ (MONTH/YEAR)

2a. Does your hospital have a committee that sets general policy for *all* inpatient education programs conducted by the hospital?

461 ☐ Yes ☐ No ☐ In planning stages

b. If yes, please specify the name of this committee. (Check *one* answer only.)

38 ☐ Executive Committee
139 ☐ Patient Care Committee
88 ☐ Patient Education Committee
196 ☐ Other (please specify) _____

c. If yes, please indicate which of the following have membership on this committee. (Check as many as applicable.)

331 ☐ Physician
432 ☐ RN
35 ☐ Trustee
24 ☐ Consumer (other than hospital personnel)
264 ☐ Administrator
135 ☐ Social Worker
211 ☐ Educator
113 ☐ Pharmacist
26 ☐ Auxilian/volunteer
181 ☐ Dietitian
38 ☐ Patient representative
168 ☐ Other (please specify) _____

3a. Has a specific hospital department been designated to coordinate inpatient education activities?

218 ☐ Yes ☐ No ☐ In planning stages

b. If yes, which department has this responsibility? (Check *one* answer only.)

18 ☐ Administration
298 ☐ Education

701 ☐ Nursing
5 ☐ Public relations
11 ☐ Social service
7 ☐ Personnel
178 ☐ Other (please specify) _____

c. Is there a person from this department designated to coordinate inpatient education in your hospital?
1030 ☐ Yes ☐ No

d. If yes, what is his/her title? _____

e. Does this person devote all of his/her time to coordination of inpatient education in your hospital?
143 ☐ Yes ☐ No

4a. Do you use outside consultants to help plan your inpatient education program?
840 ☐ Yes ☐ No

b. If yes, please name the institution(s)/organization(s) in which they are employed.

_____

_____

_____

5. Are funds budgeted for patient education in your hospital?
694 ☐ Yes ☐ No

6a. What are the dollar sources for inpatient education in your hospital? (Check as many as applicable.)
1572 ☐ Revenues generated by daily rates
200 ☐ Separate billing
415 ☐ Gifts or grants

b. If your hospital bills separately for inpatient education, please indicate the items/services for which you specifically charge. (Check as many as applicable.)
99 ☐ Educational materials
85 ☐ Group classes
64 ☐ Educational services performed by someone other than the staff on the patient unit
54 ☐ Set fee for each educational service
30 ☐ Other (please specify) _____

B. SPECIFIC HOSPITAL PROGRAMS

1. What inpatient education programs for specific patient population does your hospital conduct? (Check as many as applicable.)

	Adult		Pediatric	
	Operational	In planning stages	Operational	In planning stages
Alcohol and drug dependency	452 ☐	☐	44 ☐	☐
Arthritis	145 ☐	☐	28 ☐	☐
Cancer				
Ostomy	1337 ☐	☐	195 ☐	☐
Mastectomy	1275 ☐	☐	NA	NA

Other cancers	378 ☐	☐	81 ☐	☐
Death and dying	317 ☐	☐	100 ☐	☐
Dental	89 ☐	☐	62 ☐	☐
Diabetes	2097 ☐	☐	960 ☐	☐
Diagnostic tests	617 ☐	☐	226 ☐	☐
Exercise	677 ☐	☐	208 ☐	☐
Family planning	473 ☐	☐	32 ☐	☐
Gastrointestinal	188 ☐	☐	52 ☐	☐
Genitourinary	196 ☐	☐	69 ☐	☐
Glandular	41 ☐	☐	18 ☐	☐
Heart and circulatory				
Pacemaker	794 ☐	☐	64 ☐	☐
Stroke	849 ☐	☐	NA	NA
Hypertension	658 ☐	☐	50 ☐	☐
Heart attack	1263 ☐	☐	NA	NA
Congestive heart failure	604 ☐	☐	42 ☐	☐
Open-heart surgery	266 ☐	☐	87 ☐	☐
Kidney	309 ☐	☐	106 ☐	☐
Nutrition	1453 ☐	☐	537 ☐	☐
Orientation to hospital for patients	790 ☐	☐	485 ☐	☐
Orthopedic	506 ☐	☐	206 ☐	☐
Prenatal	1426 ☐	☐	47 ☐	☐
Postnatal	1200 ☐	☐	72 ☐	☐
Preoperative	1186 ☐	☐	484 ☐	☐
Postoperative	894 ☐	☐	348 ☐	☐
Respiratory	906 ☐	☐	247 ☐	☐
Visual or hearing	155 ☐	☐	72 ☐	☐
Other (please specify)				
_____	352 ☐	☐	94 ☐	☐
_____	124 ☐	☐	42 ☐	☐
_____	50 ☐	☐	16 ☐	☐
No specific programs	31 ☐		1265 ☐	

2. Which of the following help plan and/or teach in specific inpatient programs? (Check as many as applicable.)

Categories	Plan	Teach
Physicians	1557 ☐	1150 ☐
RNs on inpatient units	2181 ☐	2503 ☐
LPNs on inpatient units	899 ☐	1569 ☐
Aides, attendants, and orderlies	272 ☐	594 ☐
Dietitians/nutritionists	2002 ☐	2260 ☐
Pharmacists	640 ☐	489 ☐
Social work staff	930 ☐	857 ☐
Administrative staff	586 ☐	217 ☐

Nursing in-service staff	1830 ☐	1558 ☐
Occupational therapists	492 ☐	541 ☐
Physical therapists	1284 ☐	1507 ☐
Respiratory therapists	1065 ☐	1269 ☐
Speech and hearing therapists	374 ☐	442 ☐
Clergy	400 ☐	408 ☐
Hospital volunteers	179 ☐	232 ☐
Public relations staff	200 ☐	61 ☐
Dentists	110 ☐	127 ☐
Medical library staff	193 ☐	49 ☐
Psychologists	219 ☐	207 ☐
Education staff	594 ☐	502 ☐
Patient representatives	162 ☐	175 ☐
Community support groups (for example, A.A., ostomy clubs, and so forth)	858 ☐	1151 ☐
Other (please specify) _____	189 ☐	207 ☐
_____	61 ☐	58 ☐

3. How is an initial assessment of the patient and/or family's health education needs done? (Check as many as applicable.)

1878 ☐ As part of the history taken by health personnel
449 ☐ As part of the history sheet filled out by the patient and/or family
724 ☐ As a separate interview for patient education by staff
116 ☐ As a separate sheet for patient education filled out by patient and/or family
381 ☐ Not done
355 ☐ Other (please specify) _____

_____

4. How is each individual patient and/or family health education program initiated? (Check as many as applicable.)

933 ☐ Standing order – all patients with the specified health need will receive this unless M.D. orders otherwise
1941 ☐ Physician order
1879 ☐ By nurse or other health professional (for example, pharmacist, social worker, and so forth)
177 ☐ Other (please specify) _____

_____

5. When does formal planning take place for an *individual's* patient education program? (Check as many as applicable.)

1568 ☐ During nursing care conference
1213 ☐ During patient care conference between nursing staff and physician
649 ☐ During specific conference for patient education with physician and nurse
661 ☐ During patient care conference of multidisciplinary team
236 ☐ During patient education conference of the multidisciplinary team
369 ☐ Not done
256 ☐ Other (please specify) _____

_____

6a. For which of the following are your inpatient education programs conducted? (Check as many as applicable.)

1262 ☐ Patients only

2477 ☐ Patients in conjunction with family members or friends who have a responsibility to patient

228 ☐ Families and friends only

b. Which of the following help the patients learn? (Check as many as applicable.)

2579 ☐ Hospital personnel as individual teachers (for example, physician, nurse, dietitian, educator)

1024 ☐ Hospital personnel as members of a multidisciplinary teaching team

1170 ☐ One other person with the same health problem

236 ☐ A volunteer (not someone with the same health problem)

839 ☐ Small groups (not more than 10) of other patients

317 ☐ Large groups (more than 10) of other patients

c. Which of the following do you use for inpatient education? (Check as many as applicable.)

	Externally produced	Self-produced
Films	1412 ☐	97 ☐
Filmstrips	1464 ☐	38 ☐
Slides	886 ☐	328 ☐
Slide-tapes	487 ☐	188 ☐
Audiotapes	997 ☐	157 ☐
Video programs	458 ☐	249 ☐
Bulletin boards or exhibits	879 ☐	592 ☐
Models	1088 ☐	159 ☐
Posters	1032 ☐	594 ☐
Telephone dial access	211 ☐	74 ☐
Printed materials		
Brochures, booklets, pamphlets	2487 ☐	840 ☐
Self-instruction/programmed learning	871 ☐	209 ☐
Flip charts	1230 ☐	232 ☐
Other (please specify) _____	89 ☐	130 ☐
_____	20 ☐	42 ☐

7. Does your hospital have a patient education center for patients and/or families to come for learning experiences?

253 ☐ Yes ☐ No ☐ In planning stages

8a. Is specific provision made for documentation in the medical records of inpatient education activities?

1809 ☐ Yes ☐ No ☐ In planning stages

b. If yes, where?
(Check as many as applicable.)

1442 ☐ Nursing progress notes
580 ☐ Physician progress notes
267 ☐ Integrated progress notes
523 ☐ Separate recording sheet for patient education
570 ☐ Discharge planning sheet

9. Is assessment of the patient's and/or family's educational outcomes included in any of the following?
(Check as many as applicable.)

457 ☐ Medical audit
1842 ☐ Nursing audit
206 ☐ Combined audit
708 ☐ None of the above

10. Does your hospital send information about the individual patient's and/or family's inpatient education experiences to any of the following?
(Check as many as applicable.)

264 ☐ Outpatient department
643 ☐ Physician
850 ☐ Public health department
1446 ☐ Nursing home
1132 ☐ Visiting nurses' association
431 ☐ Patient
737 ☐ None
213 ☐ Other (please specify)_____

11a. Do you use any of the following methods to gain information about the impact of inpatient education on the patient and/or family? Please indicate whether the procedure is used for none, some (one or more), or all of your inpatient education programs.

	None	Some	All
Interview or questionnaire to determine patient and/or family attitudes toward the program	1619 ☐	913 ☐	139 ☐
Interview or questionnaire of information retained by patient and/or family	1683 ☐	828 ☐	160 ☐
Observation of patient and/or family performing tasks	539 ☐	1476 ☐	656 ☐
Interview or questionnaire of staff conducting program	1768 ☐	769 ☐	134 ☐
Interview or questionnaire of attending physicians	2086 ☐	529 ☐	56 ☐
Other (please specify)_____	NA	34 ☐	12 ☐
_____	NA	9 ☐	7 ☐

b. When does evaluation of patient and/or family learning take place? Please indicate whether this evaluation occurs in none, some (one or more), or all of your inpatient education programs.
(Check as many as applicable.)

	None	Some	All
Before the patient leaves the inpatient setting	299 ☐	1474 ☐	898 ☐
During a visit to the outpatient department	1959 ☐	677 ☐	35 ☐
In a physician's office	1867 ☐	781 ☐	23 ☐
During a home visit	1994 ☐	653 ☐	24 ☐
By a telephone follow-up	2058 ☐	594 ☐	19 ☐
By a mail survey	2420 ☐	225 ☐	26 ☐
Other (please specify) _____	NA	53 ☐	10 ☐
_____	NA	7 ☐	1 ☐

c. Which of the following do you use to evaluate your inpatient education programs? Please indicate whether the method of analysis is used for none, some (one or more), or all of your inpatient education programs.

	None	Some	All
Records kept of number of patients and/or families given health education programs	1480 ☐	767 ☐	424 ☐
Interview of staff involved in programs	1418 ☐	1072 ☐	181 ☐
Statistical comparisons of patient readmission rates	2423 ☐	219 ☐	29 ☐
Analysis of inpatient education referrals per total admissions	2516 ☐	126 ☐	29 ☐
Analysis of information retained by patient or family	2013 ☐	570 ☐	88 ☐
Analysis of patient and/or family behavior change	1865 ☐	715 ☐	91 ☐
Other (please specify) _____	NA	☐	☐
_____	NA	☐	☐

C. QUESTIONNAIRE EVALUATION

Did you have any difficulty with any of the questions? (Please specify.) ☐ ☐

_____

_____

_____

_____

_____

Please comment on any areas of your inpatient education program not covered by this questionnaire.

_____

_____

_____

_____

_____

_____

DATE

SIGNATURE OF ADMINISTRATOR

If we have any questions, whom shall we contact for clarification?

_____

NAME (PLEASE PRINT)

TITLE

_____

HOSPITAL

CITY, STATE

AREA CODE / TELEPHONE NUMBER

Please list by name and title any other individual(s) who helped complete this questionnaire.

NAME (PLEASE PRINT)	TITLE	NAME (PLEASE PRINT)	TITLE
NAME (PLEASE PRINT)	TITLE	NAME (PLEASE PRINT)	TITLE

Appendix 2.

AHA INPATIENT EDUCATION PROJECT
82 SITE HOSPITALS LISTED BY BED SIZE

Hospital	Bed Size
(6 – 199)	
Watonwan Memorial Hospital St. James, MN	32
Pembina County Memorial Hospital Cavalier, ND	41
Monte Sano Hospital Los Angeles, CA	51
Hutchinson Community Hospital Hutchinson, MN	67
Bradley Memorial Hospital Southington, CT	80
Athens-Limestone Hospital Athens, AL	90
Madison County Hospital London, OH	96
Woodruff Community Hospital Long Beach, CA	99
Whittier Hospital Whittier, CA	101
Brent General Hospital Detroit, MI	116
St. Francis Hospital Roslyn, NY	125
St. Mary's Hospital Athens, GA	139
Sherman Oaks Community Hospital Sherman Oaks, CA	141
Margate General Hospital Margate, FL	149
Bay Harbor Hospital Harbor City, CA	150
Downey Community Hospital Downey, CA	151
Long Beach Memorial Hospital Long Beach, NY	159
Biscayne Medical Center Miami, FL	161
Hunterdon Medical Center Flemington, NJ	165
Holy Name of Jesus Hospital Gadsden, AL	183
(200 – 299)	
Park City Hospital Bridgeport, CT	204
Brookhaven Memorial Hospital Patchogue, NY	216
Mounds Park Hospital St. Paul, MN	216
Beth Israel Hospital Passaic, NJ	221
Lydia E. Hall Hospital Freeport, NY	221
Carle Foundation Hospital Urbana, IL	223
St. Clare's Hospital Denville, NJ	230
Shore Memorial Hospital Somers Point, NJ	234
Seaway Hospital Trenton, MI	236
Cedars of Lebanon Hospital Miami, FL	252
Bethesda Memorial Hospital Boynton Beach, FL	259
St. Anthony Hospital Columbus, OH	263
Fort Hamilton-Hughes Memorial Hospital Hamilton, OH	270
Central Baptist Hospital Lexington, KY	271
Hall County Hospital Gainesville, GA	271
Inter-Community Hospital Covina, CA	274
Augustana Hospital & Health Care Center Chicago, IL	292
Lutheran Medical Center Omaha, NE	293
Bethesda Lutheran Hospital St. Paul, MN	298
St. Mary of Nazareth Hospital Center Chicago, IL	298
(300 – 399)	
Baptist Hospital of Miami Miami, FL	301
Mount Sinai Hospital Hartford, CT	305
Mercy Hospital Hamilton, OH	306
St. John's Queens Hospital Flushing, NY	308
Children's Hospital of Michigan Detroit, MI	310
Piedmont Hospital Atlanta, GA	314
St. Vincent's Medical Center Bridgeport, CT	315
United Hospital Grand Forks, ND	316
Our Lady of Lourdes Hospital Camden, NJ	334
St. Luke's Hospitals Fargo, ND	364
Elizabeth General Hospital & Dispensary Elizabeth, NJ	369
St. John's Hospital St. Paul, MN	387
(400 – 499)	
Middletown Hospital Middletown, OH	400

AHA INPATIENT EDUCATION PROJECT
82 SITE HOSPITALS LISTED BY BED SIZE
Cont'd

Hospital	Bed Size
South Chicago Community Hospital Chicago, IL	400
Morristown Memorial Hospital Morristown, NJ	430
Methodist Hospital of Gary Gary, IN	440
Ravenswood Hospital Medical Center Chicago, IL	440
Bethesda Hospital Cincinnati, OH	470
Hackensack Hospital Hackensack, NJ	471
Riverview Hospital Red Bank, NJ	471
Methodist Hospital Minneapolis, MN	475
Perth Amboy General Hospital Perth Amboy, NJ	483
St. Francis Medical Center Trenton, NJ	483
Bayfront Medical Center St. Petersburg, FL	497
	(500 or more)
Mommouth Medical Center Long Branch, NJ	501
St. Joseph Medical Center Burbank, CA	514
St. Francis Hospital of Lynwood Lynwood, CA	524
Bridgeport Hospital Bridgeport, CT	531
Memorial Hospital Hollywood, FL	543
Huntsville Hospital Huntsville, AL	544
St. Mary Medical Center Gary, IN	559
Jewish Hospital of Cincinnati Cincinnati, OH	595
United Hospitals St. Paul, MN	646
Good Samaritan Hospital Cincinnati, OH	721
Cedars-Sinai Medical Center Los Angeles, CA	737
Abbott-Northwestern Hospital Corporation Minneapolis, MN	801
Ohio State University Hospitals Columbus, OH	955
Henry Ford Hospital Detroit, MI	1008
Grady Memorial Hospital Atlanta, GA	1058
Methodist Hospital of Indiana Indianapolis, IN	1074
Fairview Community Hospitals Minneapolis, MN	1080
James M. Jackson Memorial Hospital Miami, FL	1191

Appendix 3.

HOSPITALS, BY BED SIZE, WITH A COMMITTEE THAT SETS GENERAL POLICY FOR ALL INPATIENT EDUCATION PROGRAMS

Bed Size	Hospitals Reporting on Survey	Hospitals Reporting a Committee		Name of Committee							
				Executive Committee		Patient Care Committee		Patient Education Committee		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Total	2,680	461	17.2	38	8.2	139	30.2	88	19.1	196	42.5
6–199 beds	1,516	256	16.9	19	7.4	89	34.8	36	14.1	112	43.7
200–299	477	80	16.7	7	8.7	20	25.0	19	23.7	34	42.5
300–399	286	51	17.8	7	13.7	13	25.5	13	25.5	18	35.3
400–499	178	32	18.0	2	6.3	9	28.1	10	31.3	11	34.4
500 and over	223	42	18.8	3	7.1	8	19.0	10	23.8	21	50.0

Appendix 4.

Summary and Interpretation of "Other" In-Patient Education Policy-Setting Committees: Administrative Type

This part of the analysis utilized the data obtained from the survey, Sec. A, Item 2b, "Other" responses. Of the 196 "Other" responses, 180 specified the Committee Name.

Definition: An "other" committee was placed into an administrative-oriented category (vs. an education-oriented category) if the title:
(1) appeared to suggest a multipurpose nature, i.e., education is one of many charges; and
(2) specified an administrative function.

Total administrative titles – 96/180 (53.3%)

The "other" committee titles which were interpreted to indicate a primarily administrative (vs. educational) focus were further separated into three categories.

The three categories include committees titled (1) by management focus, (2) by membership, and (3) by patient care focus.

(1) Committees by *management focus* comprised the most frequently-cited titles (40/96). This category is subdivided into two groups (1) Audit/Evaluation - Related Committee Titles and (2) Policy/Procedure - Related Committee Titles.

Bedsize						
6–199	200–299	300–399	400–499	500+	Audit/Evaluation – Related Committee Titles	(26/40)
14	1	1	–	1	Nursing Audit Committee	
1	2	–	–	–	Audit	
2	–	–	–	–	Medical and Nursing Committee	
1	–	–	–	–	Medical Care Evaluation Committee	
1	–	–	–	–	Nursing Audit/Medical Staff Committee	
–	–	–	1	–	Patient Care Evaluation Committee	
–	–	–	1	–	NCP and PSRO	
					Policy/Procedures - Related Committee Titles	(14/40)
3	–	–	–	–	Policy and Procedure Committee	
3	1	–	–	–	Policy Committee	
3	1	–	–	–	Procedure Committee	
1	–	–	–	–	Policy and Inservice Committee	
1	–	–	–	–	Program Planning Committee	
1	–	–	–	–	Advisory Committee	
31	5	1	2	1		

(2) Committee titles by *membership* (38/96). This category can broadly be subgrouped into physician groups, physician-nurse groups, nurse groups, and "others."

Bedsize						
6–199	200–299	300–399	400–499	500+	Physician Groups	(9/38)
–	1	–	–	–	Medical Board	
–	–	–	–	1	Doctors' Individual Services	
4	–	–	–	–	Medical Staff	
–	1	–	–	–	Medical Administrative Committee	
–	1	–	–	–	Medical Executive Committee	
–	–	1	–	–	Physician Advisers and Allied Medical Personnel	

Bed Size 0–199	200–299	300–399	400–499	500+	Physician-Nurse Groups	(6/38)
2	–	–	–	–	Doctor/Nurse Liaison Committee	
3	1	–	–	–	Professional Activities Committee	
					Nurse Groups	(15/38)
1	–	–	–	–	Nursing Practice and Nursing Executive	
2	–	–	–	–	Nursing Care Plan Committee	
–	1	1	–	–	Nursing Committee	
–	1	–	–	–	Nursing Practice Committee	
–	–	–	1	–	Informal Committee of Nursing Service	
1	–	–	–	–	Nursing Service Administrative	
1	–	–	–	–	Nursing Supervisory Committee	
1	–	1	–	–	Nursing Executive Committee	
1	–	–	–	–	Nursing Cabinet	
1	–	–	–	–	H.N./Supervisory Committee	
1	–	–	–	–	Supervisory Group	
1	–	–	–	–	Nursing and Administrative Committee	
					Others	(8/38)
1	–	–	–	–	Social Service Committee	
1	–	–	–	–	Administrative Council	
1	–	–	–	–	Department Head Committee	
3	–	–	–	–	Committee of the Whole	
1	–	–	–	–	Multidisciplinary Committee	
–	–	–	–	1	Management Committee	
26	6	3	1	2		

(3) Committee titles by *Patient Care Focus* (18/96). This category can be subdivided into 3 groups: specific care committees, general care committees, and "others."

6–199	200–299	300–399	400–499	500+	Specific Care Committees	(6/18)
1	–	–	–	–	Coronary Care Unit Committee	
–	–	–	–	1	Special Care Units Committee	
–	–	1	–	–	Rehabilitation Committee	
–	1	–	–	–	Critical Care Committee	
1	–	–	–	–	Surgical Care Committee	
1	–	–	–	–	Medical Intensive Care Committee	
					General Care Committee	(7/18)
1	–	–	–	–	Joint Care Committee	
–	1	–	–	–	Continuity of Patient Care Committee	
–	–	–	–	1	Patient Care Committee	
1	–	–	–	–	Patient Care Conference Committee	
2	–	–	–	–	Committee for the Improvement of Patient Care	
1	–	–	–	–	Patient Care Planning	
					Others	(5/18)
1	–	–	–	–	Parent Coordination Committee	
3	1	–	–	–	Discharge Planning Committee	
12	3	1	–	2		

Summary of "Other" Committees With An Administrative Orientation

Table (A)	T	Bed Size 6–199	200–299	300–399	400–499	500+	Administrative Committee Categories
Number Cited	40	31	5	1	2	1	By Management Focus
	38	26	6	3	1	2	By Membership
	18	12	3	1	–	2	By Clinical Focus
	96	69	14	5	3	5	
(B)							
% In Each Bed Size Group		45%	36	20	67	20	By Management Focus
		38	43	60	33	40	By Membership
		17	21	20	–	40	By Clinical Focus
		100	100	100	100	100	
(C)							
Frequency of Category		69/96	14/96	5/96	3/96	5/96	
		72%	15%	5%	3%	5%	
(D)							
Highest User of Category Among Groups		x	–	–	–	–	By Management Focus
		x	–	–	–	–	By Membership
		x	–	–	–	–	By Clinical Focus
(E)							
Most Common Category for Each Bed Size Group		x	–	–	x	–	By Management Focus
		–	x	x	–	x	By Membership
		–	–	–	–	x	By Clinical Focus

Interpretation – Tables A–E

Overview

Among those hospitals responding an administrative-oriented "other" committee:

1. Small hospitals (bed size 6–199) cited most "other" types of administrative-oriented policy committees. When all data by bed size group were adjusted for differences in response number, small hospitals remained the predominant users of administrative-oriented "other" titles (61.6%).
2. There are differences by bed size as to what category is preferred when administrative-oriented-other committees are cited, i.e., bed size 6–199 tend to use administrative committee with titles *by management focus*; bed size 200–399 tend to use administrative committee with titles *by membership*; bed size 400–499 tend to use administrative committee with titles *by management focus*; and, bed size 500+ tend to use administrative committee with titles *by membership* or *patient care focus*.
3. Larger bed size hospitals (500+) show very little overall use of "other" administrative-oriented committee titles.
4. The most common "other" administrative-oriented committee title for all categories is Nursing Audit Committee.
5. The most common titles of each category are:

   Nursing Audit Committee (by management focus)
   Medical Staff Committee (by membership)
   Discharge Planning Committee (patient care focus)

Hospital Bed Size 6–199

1. As mentioned, these hospitals cite most committees in this section. There is a slightly stronger tendency to cite *management focus* titles, (45%) vs *by membership* titles (38%) vs *by patient care focus* titles (17%). Within *management focus* committees, these hospitals more commonly use audit/evaluation--

related committee titles, especially nursing audit committee. Common use of this particular committee is seen to occur only in this hospital size.

2. When *membership*-titled committees are cited, small hospitals have a tendency to have a nursing or a multidiscipline group, although the most commonly cited title in the *by membership* category is "medical staff."
3. These hospitals cited the most kinds of committees by *patient care focus*, although these only comprise 17 percent of all committees cited by this group. There is no trend in commonly-cited committee titles by *patient care focus*.

Hospital Bedsize 200-499

1. As a group, these hospitals tend to cite committees by *membership* slightly more commonly than other two types of committee.
2. Regarding committees *by management focus*: audit/evaluation-related is more common than policy/ procedure titles.
3. Regarding committees *by membership*: most commonly cited nursing-related committees; seldomly cite multidisciplinary-related committees.
4. Regarding committees *by patient care focus*: seldomly used, no trends.

Hospital Bedsize 500+ (Small data base prevents significant interpretation).

Appendix 5.

Summary and Interpretation of "Other" Inpatient Education Policy-Setting Committees: Education-Type

This part of the analysis utilized the data obtained from the survey, Sec. A, Item 2b, "Other" responses. Of the 196 "Other" responses, 180 specified the Committee Name.

Definition: An "other" committee was placed into an education-oriented category (vs an administrative-oriented category) if the title includes the term education, i.e., places a focus on the formulization of education, either for patients or for staff.

Total educational committee titles – 84/180 (46.7%)

The committee titles which were interpreted to indicate a primarily *educational* (vs administrative) focus were further separated into four categories.

(1) Those which retain a staff-education item, to suggest that the patient education task is/was related to staff education work in some way (e.g., same staff to do both; both seen as substantially similar tasks, etc.).

Committee titles in this category are the most frequently cited (44/84) (52.4%).

The following committee titles are included in this category:

Bed Size					
6–199	200–299	300–399	400–499	500+	
–	–	–	–	1	Nursing Education Committee
1	–	–	–	–	Nursing Staff Development
1	–	–	–	–	Nursing Care Education
1	–	–	–	–	Nursing (Service) Inservice Committee
5	1	–	–	–	Inservice Committee
1	–	–	–	–	Inservice Coordination Committee
9	1	–	–	–	Inservice Education Committee
1	–	–	–	–	Inservice Planning Committee
3	–	–	–	1	Staff Development Committee
–	–	–	1	–	Staff Education Department
–	1	–	–	–	Education Staff Meeting
–	1	–	–	–	Human Resource Development
1	–	–	–	–	Medical Education & Continuing Care Committees
1	1	1	1	–	Medical Education Committee
–	1	–	–	–	Medical Education & Program Planning Committees
–	1	–	–	–	Medical Education & Education Committees
–	–	1	–	–	Subcommittee of Continuing Medical Education
–	1	–	–	–	Hospital Education Committee
–	1	–	–	–	Hospital Education Coordination Committee
1	–	1	–	–	Joint Education Committee
1	1	–	–	–	Continuing Education Committee
–	1	–	–	–	Education and Training Department
–	–	–	1	–	Department for Employee & Patient Education
26	11	3	3	2	

(2) Those which contain a patient/community orientation, suggesting patient education is viewed as a new or separate entity. (16/84) (19.0%).

The following committee titles are included in this category:

Bed Size					
0–199	200–299	300–399	400–499	500+	
–	1	1	–	1	Patient Teaching Committee
1	–	–	–	–	Parent Teaching Committee
–	1	–	–	–	Education & Community Government Relations

Bed Size 6–199	200–299	300–399	400–499	500+	
1	–	–	–	–	Patient & Community Education Committee
–	–	–	–	1	Patient Affairs and Education Committee
–	1	–	–	–	Discharge Planning – Patient Education
1	–	–	–	–	Executive & Patient Education Committee
1	–	–	–	–	Patient Teaching Guidelines Committee
–	–	1	–	–	Patient and Health Education
1	–	–	–	–	Ad Hoc Patient Education Committee
2	–	–	–	–	Patient Education Advisory Committee
1	–	–	–	–	Patient Education Study Committee
–	–	–	1	–	Department for Employee & Patient Education
8	3	2	1	2	

(3) Those which are general in nature, which may or may not be related to staff education tasks. (19/84) (22.6%).

The following committee titles are included in this category:

Bed Size 0–199	200–299	300–399	400–499	500+	
3	3	3	1	2	Education Committee (Council)
2	–	–	–	2	Health Education Committee
–	1	–	–	–	Education Advisory Committee
–	1	–	–	–	Member Education Committee
1	–	–	–	–	Education and Research
6	5	3	1	4	

(4) Those which have a methodological (vs a person) referent (5/84) (6.0%).

The following committee titles are included in this category:

Bed Size 0–199	200–299	300–399	400–499	500+	
1	–	–	–	–	Medical Library Committee
–	–	1	–	–	Education Library Committee
–	–	1	–	–	Library
1	–	–	–	–	Library and Education Committee
1	–	–	–	–	Audio-Visual Committee
3	–	2	–	–	

"EDUCATIONAL" COMMITTEE

Table (A)	Bed Size T	0–199	200–299	300–399	400–499	500+	Education-Oriented Categories
Number Cited	44	26	10	3	3	2	Staff
	16	8	3	2	1	2	Patient-Community
	19	6	5	3	1	4	General Education
	15	3	0	2	0	0	Methodologic Referent
	84	43	18	10	5	8	

(B)							
% in each bed size group	52%	60%	55%	30%	60%	25%	Staff
	19%	19%	17%	20%	20%	25%	Community-Patient
	23%	14%	28%	30%	20%	50%	General Education
	6%	7%	–	20%	–	–	Methodologic Referent
		100%	100%	100%	100%	100%	
(C)							
Frequency of Category		43/84	18/84	10/84	5/84	8/84	
		51%	21%	12%	6%	10%	
(D)							
Highest user of category among groups		x	–	–	–	–	Staff
		x	–	–	–	–	Community-Patient
		x	–	–	–	–	General Education
		x	–	–	–	–	Methodologic Referent
(E)							
Most common category for each bed size group		x	x	x	x	–	Staff
		–	–	–	–	–	Patient-Community
		–	–	x	–	x	General Education
		–	–	–	–	–	Methodologic Referent

Interpretation – Tables A–E

Overview

Among those hospitals responding on education-oriented "other" committee:

1. When all data by bed size group were adjusted for differences in response number, hospitals of bed size 300–399 were found to be the most frequent users of education-oriented "other" titles (55.6%).
2. Except for larger hospitals (500+), there is a tendency for policy about patient education to emanate from a staff education-oriented committee (Tables B and E). In the larger hospitals (500+), this committee is more likely to be a general education-oriented committee.
3. The smaller hospitals (6–199) and medium-large hospitals (300-399) cited policy committees oriented to methodologic supports (library and A/V), but these were generally least commonly cited committees.
4. The most common education-oriented committee titles were:
   Education Committee
   Inservice Education Committee
5. Most common titles of each category were:
   Inservice Education Committee (staff education oriented)
   Patient Teaching Committee (patient-community oriented)
   Education Committee (general education)
   Library Committee (methodologic referents)

Hospital Bed size 6–199

1. As mentioned most of the "other" policy-making committees were in the Staff-Oriented Educational Committees. In this group, committee titles cited were clustered in the inservice and nursing education areas.
2. There was no definable cluster in Patient-Community Committee titles (i.e., every small hospital had its own unique title for committee with patient-community orientation).
3. Committees and general education titles tended to be called simply Education or Health Education Committee.
4. Small hospitals cited most use of methodologic referent committees (library and A/V), as patient education policy-setters.
5. Most common "educational" committee title: Inservice Education Committee.

Hospital Bed size 200–499

1. This group tended to have education committees and a staff-education orientation. These tended *not* to be nursing or inservice, but rather Medical Education or Non-Specific Staff-Oriented Committees.
2. General Education Committee titles were slightly more common than patient-community-oriented committee titles. The likely title of the general education committee is "Education Committee."
3. There is no trend in titles related to patient-community-oriented committees.
4. Of this group, only hospitals of bed size 300–399 indicate the use of Library-referent committees for patient education policy-setting.
5. Most common "educational" committee title: Education Committee.

Hospital Bed size 500+

1. This group is most likely to have a general education-related committee, named either "education" or "health education" committee.
2. There is an equal likelihood for this group to have a patient-community-oriented or a staff-oriented committee title (especially nursing or non-specific staff) if not a general education-related committee.
3. There were no cited titles of committees with library or A/V referents as policy-setting in patient education.
4. Most common "educational" committee title: (Health) Education Committee.

Appendix 6.

**"Other" Policy-setting Committee Titles,
With Membership from more than one Dicipline
From 180 Responses Specifying "Other" Committee:
Refer to Survey Sec. A, Item 2b.**

Bed Size					
6–199	200–299	300–399	400–499	500+	Administrative Oriented Committee Titles
1	2	–	–	1	Audit
2	–	–	–	–	Medical and Nursing Audit
1	–	–	–	–	Nursing Audit/Medical Staff Committee
–	–	–	1	–	Patient Care Evaluation Committee
–	–	–	1	–	NCP and PSRO
3	–	–	–	–	Policy and Procedure Committee
3	1	–	–	–	Policy Committee
3	1	–	–	–	Procedure Committee
1	–	–	–	–	Policy and Inservice Committee
1	–	–	–	–	Program Planning Committee
1	–	–	–	–	Advisory Committee
–	–	1	–	–	Physician Advisers and Allied Medical Personnel
2	–	–	–	–	Doctor/Nurse Liaison Committee
3	1	–	–	–	Professional Activities Committee
1	–	–	–	–	Nursing and Administrative Committee
1	–	–	–	–	Administrative Council
1	–	–	–	–	Department Head Committee
3	–	–	–	–	Committee of the Whole
1	–	–	–	–	Multidisciplinary Committee
–	–	–	–	1	Management Committee
1	–	–	–	–	Coronary Care Unit Committee
–	–	–	–	1	Special Care Unit's Committee
–	–	1	–	–	Rehabilitation Committee
–	1	–	–	–	Critical Care Committee
1	–	–	–	–	Surgical Care Committee
1	–	–	–	–	Medical Intensive Care Committee
1	–	–	–	–	Joint Care Committee
–	1	–	–	–	Continuity of Patient Care Committee
–	–	–	–	1	Patient Care Committee
1	–	–	–	–	Patient Care Conference Committee
2	–	–	–	–	Committee for the Improvement of Patient Care
1	–	–	–	–	Patient Care Planning
1	–	–	–	–	Parent Coordination Committee
3	1	–	–	–	Discharge Planning Committee
					Education Oriented Committee Titles
5	1	–	–	–	In-service Committee
1	–	–	–	–	In-service Coordination Committee
9	1	–	–	–	In-service Education Committee
1	–	–	–	–	In-service Planning Committee
3	–	–	–	1	Staff Development Committee
–	–	–	1	–	Staff Education Department
–	1	–	–	–	Education Staff Meeting
–	1	–	–	–	Human Resource Development
1	–	–	–	–	Medical Education and Continuing Care Committee
–	1	–	–	–	Joint Committee Hospital Education
–	–	1	–	–	Joint Committee of Continuing Education and Medical Education

Bed Size					
0–199	200–299	300–399	400–499	500+	Education Oriented Committee Titles
–	1	–	–	–	Hospital Education Coordination Committee
1	–	1	–	–	Joint Education Committee
1	1	–	–	–	Continuing Education Committee
–	1	–	–	–	Education and Training Department
–	–	–	1	–	Department for Employee and Patient Education
–	1	1	–	1	Patient Teaching Committee
1	–	–	–	–	Parent Teaching Committee
–	1	–	–	–	Education and Community Government Relations
1	–	–	–	–	Patient and Community Education Committee
–	–	–	–	1	Patient Affairs and Education Committee
–	1	–	–	–	Discharge Planning – Patient Education
1	–	–	–	–	Executive and Patient Eduation Committee
1	–	–	–	–	Patient Teaching Guidelines Committee
–	–	1	–	–	Patient and Health Education
1	–	–	–	–	Ad Hoc Patient Education Committee
2	–	–	–	–	Patient Education Advisory Committee
1	–	–	–	–	Patient Education Study Committee
–	–	–	1	–	Department for Employee and Patient Education
3	3	3	1	2	Education Committee (Council)
2	–	–	–	2	Health Education Committee
–	1	–	–	–	Education Advisory Committee
–	1	–	–	–	Member Education Committee
1	–	–	–	–	Education and Research
1	–	–	–	–	Library and Education Committee
1	–	–	–	–	Audio-Visual Committee
78	24	9	6	11	

Appendix 7.

Personnel With Membership on the Hospital Committee for Inpatient Education by Bed Size and Committee

	Hospitals Reporting on Survey	Hospitals Reporting a Committee		Number of Hospitals											
				Physician		RN		Trustee		Consumer		Administrator		Social Worker	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Total	2,680	461	17.2	331	71.8	432	93.7	35	7.6	24	5.2	264	57.3	135	29.3
6–199	1,516	256	16.9	168	65.6	247	96.5	18	7.0	11	4.3	140	54.7	76	29.7
200–299	477	80	16.7	63	78.7	74	92.5	4	5.0	4	5.0	45	56.3	24	30.0
300–399	286	51	17.8	43	84.3	45	88.2	6	11.8	2	3.9	33	64.7	11	21.6
400–499	178	32	18.0	24	75.0	31	96.9	4	12.5	7	21.9	19	59.4	14	43.8
500 and over	223	42	18.8	33	78.6	35	83.3	3	7.1	0	0	27	64.3	10	23.8
All Committees		461		331	71.8	432	93.7	35	7.6	24	5.2	264	57.3	135	29.3
Executive Committee		38		36	94.7	21	55.3	8	21.1	2	5.3	31	81.6	1	2.6
Patient Care Committee		139		115	82.7	139	100.0	9	6.5	4	2.9	90	64.7	43	30.9
Patient Education Committee		88		58	65.9	88	100.0	2	2.3	10	11.4	43	48.9	37	42.0
Other		196		122	62.2	184	93.9	16	8.2	8	4.1	100	51.0	54	27.6

	Hospitals Reporting on Survey	Hospitals Reporting a Committee		Number of Hospitals											
				Educator		Pharmacist		Auxilian/ Volunteer		Dietitian		Patient Rep.		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Total	2,680	461	17.2	211	45.8	113	24.5	26	5.6	181	39.3	38	8.2	168	36.4
6–199 beds	1,516	256	16.9	101	39.5	62	24.2	12	4.7	100	39.1	14	5.5	90	35.2
200–299	477	80	16.7	46	57.5	24	30.0	4	5.0	34	42.5	3	3.7	33	41.2
300–399	286	51	17.8	26	51.0	11	21.6	4	7.8	19	37.3	7	13.7	21	41.2
400–499	178	32	18.0	17	53.1	8	25.0	5	15.6	12	37.5	7	21.9	9	28.1
500 and over	223	42	18.8	21	50.0	8	19.0	1	2.4	16	38.1	7	16.7	15	35.7
All Committees		461		211	45.8	113	24.5	26	5.6	181	39.3	38	8.2	168	36.4
Executive Committee		38		5	13.2	4	10.5	3	7.9	2	5.3	2	5.3	2	5.3
Patient Care Committee		139		53	38.1	37	26.6	3	2.2	57	41.0	10	7.2	46	33.1
Patient Education Committee		88		61	69.3	28	31.8	11	12.5	49	55.7	12	13.6	41	46.6
Other		196		92	46.9	44	22.4	9	4.6	73	37.2	14	7.1	79	40.3

Appendix 8.

Rank Order of Personnel with Membership on the Hospital Committee for Inpatient Education

Personnel	Membership by %
RN	93.7
Physician	71.8
Administrator	57.3
Educator	45.8
Dietitian	39.3
Other	36.4
Social Worker	29.3
Pharmacist	24.5
Patient Representative	8.2
Trustee	7.6
Auxilian/Volunteer	5.6
Consumer	5.2

Appendix 9.

Number of Hospitals, by Bed Size, with a Department Designated to Coordinate Inpatient Education, by Type of Department

	Total Hospitals With Dept.	Department Responsible															
		Administration		Education		Nursing		Public Relations		Social Service		Personnel		Other			
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
U.S. Total	1,218	18	1.5	298	24.5	701	57.6	5	0.4	11	0.9	7	0.6	178	14.6		
6–199 Beds	696	13	1.9	147	21.1	426	61.2	3	0.4	8	1.2	3	0.4	96	13.8		
200–299	244	3	1.2	75	30.7	124	50.8	1	0.4	1	0.4	1	0.4	39	16.0		
300–399	122	1	0.8	28	23.0	74	60.7	1	0.8	2	1.6	1	0.8	15	12.3		
400–499	76	1	1.3	23	30.3	39	51.3	0	0	0	0	0	0	13	17.1		
500 and over	80	0	0	25	31.3	38	47.5	0	0	0	0	2	2.5	15	18.8		

Appendix 10.

List of Department Titles Included in "Other" Coordinating Department by Bed Size

"Other" responses to survey questions regarding responsibility to coordinate inpatient education activities (Section A, Item 3b), n = 108.

Bed Size							
6–199	200–299	300–399	400–499	500+	All Responses		Education-Oriented Department Titles
26	5	2	–	1	34		In-service Education
4	3	1	–	2	10		Staff Development
3	2	1	–	–	6		Nursing Inservice
1	2	–	–	1	4		Health Education
2	–	–	1	–	3		Continuing Education
–	1	2	–	–	3		Nursing Education
1	–	–	2	1	4		Dept. of Education/Training
–	1	–	–	1	2		Education & Development
–	1	1	–	–	2		Nursing Staff Development
–	–	–	–	1	1		Nursing Continuing Education
–	–	–	–	1	1		Training Department
–	–	–	–	1	1		Human Resources Development
–	1	–	–	–	1		Medical Librarian
–	–	1	–	1	2		Patient Education Center
–	–	–	2	–	2		Patient Education
37	16	8	5	10	76	(70.4%)	
							Clinically-Oriented Department
1	1	–	–	–	2		Food Services
–	–	1	–	–	1		Clinical Nursing
1	–	–	–	–	1		Rehabilitation
–	1	–	–	–	1		Chaplaincy
1	–	–	–	–	1		Physical Therapy
1	–	–	–	–	1		Community Medicine
–	1	–	–	–	1		Medical Affairs
1	–	–	–	–	1		Nursing/Medical Staff
2	–	–	1	–	3		Allied Services
–	–	1	–	–	1		Continuing Care
7	3	2	1	–	13	(12.0%)	
							Joint-Department Responsibility
1	1	1	–	–	3		Nursing Dept. & Inservice Education
1	1	–	1	–	3		Nursing Dept. & Education
–	1	–	–	–	1		Nursing Dept. & Dept. of Education and Training
1	–	–	–	–	1		Nursing Dept. & Social Service
–	1	–	–	–	1		Education Dept. & Personnel
1	–	–	–	–	1		Education Dept. & Utilization Review
1	–	–	–	–	1		Patient Care Coordinator & Discharge Planning
5	4	1	1	–	11	(10.2%)	

Bed Size							
6–199	200–299	300–399	400–499	500+	All Responses		Administrative-Oriented Department
1	1	–	–	–	2		Utilization Review
1	1	–	–	–	2		Discharge Planning
–	–	–	–	1	1		Administrative Services
1	–	–	–	–	1		General Organization
–	1	–	–	–	1		Patient Relations Department
–	1	–	–	–	1		Referral Department
3	4	–	–	1	8	(7.4%)	

Findings of "Other" Department Coordinating Inpatient Education Activities:

1. Most (70.4%) had education-oriented titles. Of these, 81 percent were staff-education-oriented titles. Only 5 percent of education-oriented titles referred directly to patient education.
2. An overwhelmingly frequent response of Inservice Education Department (37% of all "other") occurred. There was no other title predominance.
3. 19.4 percent of the titles were either *clinical* or *administrative* in orientation. No title predominance in either group occurred.
4. 10.2 percent of "other" responses showed *joint-department* responsibility. Education Department was named (9/11) 82 percent as one of the departments of the cases in this category. Nursing Department was named (8/11) 72 percent. Smaller hospitals (6–299) were most likely to cite responses in this category.

Appendix 11.

Titles of Individuals Designated to Spend All of Their Time Coordinating Inpatient Education

Coordinator Titles	All Responses	6–199	200–299	300–399	400–499	500+
*Patient Education Coordinator	19	5	4	3	4	3
*Patient Teaching Coordinator	5	1	1	3	–	–
*Health Teaching Coordinator	1	1	–	–	–	–
*Health Education Coordinator	2	–	1	–	–	1
*Patient Care Coordinator	1	1	–	–	–	–
*Patient Information Coordinator	1	–	1	–	–	–
*Patient/Family Education Coordinator	1	–	–	1	–	–
Parent Coordinator	1	1	–	–	–	–
Inservice Education Coordinator	3	2	1	–	–	–
	34					
Director Titles						
*Director, Health Education	1	–	1	–	–	–
*Patient Education Director	1	1	–	–	–	–
*ADN – Patient Health & Education	1	–	–	1	–	–
ADN – Clinical Nursing	1	–	–	1	–	–
Director of Training	1	1	–	–	–	–
Inservice Education Director	13	12	1	–	–	–
	18					
Instructor Titles						
Patient Health Education Instructor	4	3	1	–	–	–
Clinical Instructor	1	–	1	–	–	–
Instructor	1	–	1	–	–	–
	6					
Miscellaneous Titles						
Health Educator	2	1	–	–	1	–
Health Teaching Consultant	1	–	–	–	1	–
Patient Care Consultant	1	–	1	–	–	–
Nurse Consultant	1	–	–	–	1	–
Utilization Review Coordinator	1	1	–	–	–	–
Manager, Education Services	1	–	–	1	–	–
Director, Dept. Continuing Education	1	–	–	–	1	–
Cardiac and Diabetic Teaching	1	–	–	1	–	–
Nursing Care Coordinator-Disch.Planning	1	–	1	–	–	–
Rehabilitation Nurse	1	–	–	1	–	–
Clinical Specialist	2	1	–	1	–	–
Health Services Rep.	1	1	–	–	–	–
Patient Education Supervisor	1	–	1	–	–	–
	15					
	73	32	16	13	8	4

*Identified as primarily patient education-coordinating title by inspection.

Findings of Responses to Full-Time Patient Educator Coordinator:

1. 73 respondents identified the title of the position which uses all its time in coordinating inpatient education.
2. The number of respondents with a full-time education coordinator who indicated the title of this position was inversely related to bedsize group:

Bedsize	No. of Responses	%
6 – 199	32	43.8
200 – 299	16	21.9
300 – 399	13	17.8
400 – 499	8	11.0
500+	4	5.5

3. Of the responses from the smaller hospitals (6–199), the most frequently cited title is "Inservice Education, Director" (37.5%), an improbable title for a position solely designated for patient education coordination. In fact, only 28.1 percent of smaller hospitals' responses seem to be clearly patient education-oriented titles.
4. The frequency of a full-time coordinator response is inversely related to hospital bedsize (c.f. 2) but the larger the hospital, the more likely the response was to be a title clearly and primarily patient education coordination-oriented. Comparison of primarily patient education coordination-oriented titles by bedsize:

6–199 = 31%
200–299 = 50%
300–399 = 61%
400–499 = 50%
500+ = 100%

5. Titles fell into four (4) categories:

	No.	%
Coordinator	34	47
Director	18	25
Other	15	20
Instructor	6	8

6. In 39 (53.4%) responses, reference to patient or health and to education or teaching were included as parts of the title.
7. Frequency of use of a title described in finding #6:

6–199	(12/32)	= 38%
200–299	(9/16)	= 52%
300–399	(8/13)	= 62%
400–499	(6/8)	= 75%
500+	(4/4)	= 100%

8. Breakdown of tendency to use categories of titles by bedsize: (predominant category in bedsize group is underscored)

Bed Size (%)					Categories
6–199	200–299	300–399	400–499	500+	
34	50	54	50	100	Coordinator
47	13	15	0		Director
9	19	0	0		Instructor
10	18	31	50		Miscellaneous

Appendix 12.

Job Titles and Functions Obtained From Participants of the Hospital Group Discussion Meetings

Job Descriptions: Functions

(As applied to Patient Education Activities)

Positions in which Primary Responsibility is Patient Education	DISCIPLINE	DEVELOPS/ PLANS	EVALUATES	COORDINATES OR DIRECTS	PARTICIPATES	PRIMARY PARTICIPANTS	DETERMINES CONTENT	PREPARES STAFF	LIAISON	SUPERVISES	CHAIRS COMMITTEE	BEDSIZE	Extent of Patient Education on Responsibilities of Position
Patient Teaching Coordinator	RN, BSN Preferred	X	X	X	X		Consults with medical staff, nursing, management and other departments	X	X			1080	
Co-ordinator, Patient Education	RN, with MA or MS in nursing/ education	X	X	X			X	X	X	X	X	314	
Director of Patient Care/Teaching Programs	RN, MSN (clinical)	X	X	Directs O-P Diabetic Program	X		?	X	X	X	X	274	
Patient Education Nurse	RN, diploma, BS or MS	X	X	X	X		X	X	X			223	
Director, Health Education	RN, BSN Preferred	X	X	X	X		X	X	X	X		165	
Patient Education Coordinator	RN, BSN	X	X	X			X	X	X			139	
Co-ordinator, Patient Education	RN, BSN Preferred	X		X		X	?	X	X			386	
Nurse Clinician for Patient Teaching	RN, MSN Preferred	X	X	X	X		X	X	X	X	X	308	

Positions in which Patient Education is one of many facets of job	DISCIPLINE	DEVELOPS/ PLANS	EVALUATES	COORDINATES OR DIRECTS	PARTICIPATES	PRIMARY PARTICIPANTS	DETERMINES CONTENT	PREPARES STAFF	LIAISON	SUPERVISES	CHAIRS COMMITTEE	BEDSIZE	Extent of Patient Education on Responsibilities of Position
Rehabilitation Nursing Co-ordinator	RN, BSN, MSN Preferred	X			X	Instructs patient in home care		X	X			1080	Has responsibilities for "patient care" but not specified down to patient education
Director, Co-ordinator of Services	RN, BSN											298	"Enforces patient and family teaching"
Supervisor – Quality Assistance Program	RN, BSN											298	"Enforces patient and family teaching"
Patient Care Co-ordinator Nurse Clinician, Liaison Nurse	RN, BSN Minimum						X					unknown	General "patient care" responsibilities
Head Nurse	RN, BSN Preferred				X			X				96	Patient education is one of 28 areas of job responsibility
Part-Time Dietitian	Registered Dietitian					X On request			X	X		41	

Additional Job Titles

The following is a list of additional job titles which are concerned with staff development or which have no direct reference to patient teaching or education.

- Patient Advocate (204 beds)
- Staff Development Instructor, Professional Personnel (298 beds)
- Staff Development Instructor, Non-Professional Personnel (298 beds)
- House Supervisor (96 beds)
- Education Director (96 beds)
- Inservice Director/Assistant Director of Nursing (41 beds)
- Director of Personnel and Education (80 beds)

Definition of Functions Identified in Job Descriptions

Develops/Plans : solely or in collaboration with others, actively constructs (and/or modifies) the framework or the patient education program(s) in the institution.

Evaluates : systematically monitors (evaluates) the implementation of the patient education program(s), making recommendations for program changes based on evaluation results.

Coordinates/Directs : regulates the course of patient education activities, as performed by others.

Participates : executes *some of* the implementation of patient education programs in the institution; works in conjunction with others to provide patient education content.

Primary Participants : performs *most* or *all* of the implementation of the patient education program.

Determines Content : decides the content of information to be disseminated in the patient education programs.

Prepares Staff	:	provides instructions for staff in order to enhance staff skill in the delivery of patient education.
Liaison	:	represents nursing and acts as intermediary agent with other disciplines in matters of patient education activities.
Supervises	:	maintains a staff in a line relationship of authority.
Chairs Committee	:	is chairperson of a committee whose primary or sole function relates to patient education.

Appendix 13.

Use of Consultants To Assist Inpatient Program Planning, by All Hospitals Reporting at Least One Inpatient Education Program

TABLE 1: Hospitals Listing Consultants by Bed Size

	Reporting at Least One Prog.		Identifying Consultants		Type of Agency Reporting			
					Vol. Agencies		Non-Vol. Agencies	
ALL HOSPITALS	No. 2680	% 100	No. 559	% 20.9	No. 553	% 41.8	No. 771	% 58.2
6–199	1516	56.6	378	67.6	289	52.1	532	69.0
200–299	477	17.3	74	13.2	106	19.1	89	11.1
300–399	286	10.7	50	9.0	88	15.9	69	9.0
400–499	178	6.6	27	4.8	29	5.2	31	4.0
500+	223	8.3	30	5.4	42	7.6	50	6.5

OVERVIEW COMMENTS:

1. Total number of consultants cited: 1324.
2. The overwhelming majority of consultant users were the smaller hospitals, bed size 6–199.
3. Smaller hospitals (6-199) cited use of non-voluntary agencies approximately twice as often as voluntary agency consultants. Conversely, hospitals of larger bedsizes were slightly more apt to use voluntary than non-voluntary agency consultants.

TABLE 2: Use of Voluntary Agencies as Consultants by Bed Size

	Bed Size					
Voluntary Agency Consultant	6–199	200–299	300–399	400–499	500+	TOTAL RANK ORDER
American Cancer Society	72	30	20	9	8	139
American Heart Association	58	15	14	8	4	99
Reach to Recovery	43	18	22	3	6	92
American Diabetic Association	34	16	10	4	4	68
United Ostomy Assoc. and Clubs	31	15	10	3	6	65
Alcoholics Anonymous	14	2	1	–	4	21
American Lung Association	12	3	1	–	2	18
American Red Cross	6	–	2	–	1	9
Planned Parenthood Association	2	2	2	–	1	7
American Arthritis Foundation	2	1	–	–	–	3
American TB Association	2	–	–	–	1	3
Juvenile Diabetic Association	2	–	1	–	–	3
Childbirth Education	3	–	–	–	–	3
International Assoc. of Laryngectomists	–	2	–	–	1	3
Mental Health Association	1	–	1	–	1	3
LeLeche League	1	1	–	–	–	2
American Foundation of the Blind	–	–	1	–	1	2
Kidney Foundation	–	–	1	1	–	2
March of Dimes	1	–	–	–	–	1
Easter Seal	–	1	–	–	–	1
Sickle Cell Anemia Foundation	1	–	–	–	–	1
Epilepsy Association	–	–	1	–	–	1
Other Non-Specified	2	–	1	1	2	6
S.I.D.S.	1	–	–	–	–	1
TOTAL VOLUNTARY AGENCY CONSULTANTS	288	106	88	29	42	553

TABLE 3: Use of Non-Voluntary Agencies as Consultants, by Hospitals Surveyed

Non-Voluntary Agency Consultant Type	Bed Size 6–199	200–299	300–399	400–499	500+	TOTAL RANK ORDER
Private Agencies	123	20	24	6	11	184
Persons/Specialists	124	17	11	8	6	166
Hospitals/Medical Centers	89	16	10	4	7	126
Schools/Universities	55	12	13	8	10	98
Government Agencies	59	11	3	3	4	80
Commercial Companies	41	8	3	–	8	60
Other	41	5	5	2	4	57
TOTAL NON-VOLUNTARY AGENCY CONSULTANTS	532	89	69	31	50	771

TABLE 4: Types of Non-voluntary Consultants Used by Hospitals, by Bed Size, in Rank Order

6–199		200–299		300–399		400–499		500+	
Specialists	124	Priv.Agcys	20	Priv.Agcys.	24	Priv.Agcys.	6	Priv.Agcys.	11
Priv.Agcys.	123	Hospitals	16	Universities	13	Universities	8	Universities	10
Govt.Agcys.	59	Govt.Agcys.	11	Hospitals	10	Specialists	8	Govt.Agcys.	4
Hospitals	89	Specialists	17	Specialists	11	Hospitals	4	Hospitals	7
Universities	55	Universities	12	Govt.Agcys.	3	Govt.Agcys.	3	Specialists	6
Comm. Co.	41	Other	5	Comm. Co.	3	Comm. Co.	0	Comm. Co.	8
Other	41	Comm. Co.	8	Other	5	Other	2	Other	4
TOTAL	532		89	31	69		31		50

TABLE 5: Rank Order of Frequency of Non-voluntary Consultants Cited by Total Group

Private Agencies	184
Persons/Consultants	166
Hospitals/Med. Ctrs.	126
Universities	98
Govt. Agencies	80
Commercial Co.	60
Other	57

Explanation for Categories of Non-Voluntary Agencies as Consultants

1. **Private Agencies** includes professional and non-governmental non-profit organizations:
   American Diabetic Association
   American Public Health Association
   American (State) Hospital Association
   American (State) Nurses Association
   Area Health Education Centers/Consortia
   Association Enterostomal Therapists
   Counseling Centers/Services
   Half-Way Houses
   Health Councils/Associations/Agencies
   Home Health Agencies
   Library Services
   Mental Health Association
   State/County Medical Society
   Visiting Nurse Association
2. **Governmental Agencies** refers to local, county, state and federal administered organizations:
   County/State Health Department
   County/State Welfare Department
   Department of Family/Children Services
   Department of Health, Education, and Welfare
   Department Human Resources
   Department of Public Health
   National Institutes of Health
   Regional Medical Program
   Veterans Administration
3. **Schools/Universities** refers to: Colleges, Junior Colleges, Vocational Schools.
4. **Hospitals**, Medical Centers.
5. **Persons/Specialists** refers to persons identified for expertise in an area including: Clergy, Dentists, Educational Directors, Medical Doctors, Special[illegible] experts, Volunteers, etc.
6. **Commercial Companies** refers to corporations with primarily non-health service: audiovisual companies, pharmaceutical companies, products companies, television networks.
7. **Other**: Items (e.g., books or pamphlets), "Telephone Lecture Network", vaguely specified references, e.g., unidentified acronyms.

Appendix 14.

Number of Hospitals With Separate Billing for Patient Education, by Bed Size and Type of Item/Services Billed

	Hospitals Reporting on Surveys	Hospitals with Separate Billing		Item/Services Billed									
				Educational Materials		Group Classes		Services Performed by Someone Other Than Staff on Unit		Set Fee for Educational Service		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Totals	2,680	200	7.5	99	49.5	85	42.5	64	32.0	54	27.0	30	15.0
6–199	1,516	84	5.5	50	59.5	27	32.1	20	23.8	23	27.4	8	9.5
200–299	477	35	7.3	15	42.9	14	40.0	10	28.6	10	28.6	6	17.1
300–399	286	40	14.0	17	42.5	20	50.0	17	42.5	13	32.5	11	27.5
400–499	178	20	11.0	8	40.0	11	55.0	6	30.0	5	25.0	4	20.0
500 and over	223	21	9.4	9	42.9	13	61.9	11	52.4	3	14.3	1	4.8

Appendix 15.

Number of Hospitals with Budgeted Funds for Inpatient Education, by Bed Size and Dollar Source

	Hospitals with Budgeted Funds	Dollar Source							
		Daily Rates		Separate Billing		Gifts or Grants		Separate Billing	
		No.	%	No.	%	No.	%	No.	%
U.S. Total	694	423	61.0	5	0.7	29	4.2	51	7.3
6–199 beds	289	183	63.3	2	0.7	15	5.2	16	5.5
200–299	157	101	64.3	0	0	6	3.8	10	6.4
300–399	94	56	59.6	0	0	2	2.1	13	13.8
400–499	64	37	57.8	0	0	3	4.7	7	10.9
500 +	90	46	51.1	3	3.3	3	3.3	5	5.6

	Hospitals with Budgeted Funds	Dollar Source (cont.)							
		Daily Rates and Gifts or Grants		Separate Billing and Gifts or Grants		Daily Rates Separate Billing Gifts or Grants		Nonresponse	
		No.	%	No.	%	No.	%	No.	%
U.S. Total	694	128	18.4	6	0.9	35	5.0	17	2.4
6–199 beds	289	49	17.0	3	1.0	12	4.2	9	3.1
200–299	157	31	19.7	1	0.6	4	2.5	4	2.5
300–399	94	12	12.8	1	1.1	8	8.5	2	2.1
400–499	64	12	18.8	1	1.6	4	6.3	0	0
500 +	90	24	26.7	0	0	7	7.8	2	2.2

Appendix 16.

Examples of Utilization of Staff and Staff Time Spent on Patient Education

Type of Program	Staff Participants in Program	Organization Time
HYPERTENSION		
Program A	R.N. staff, on rotation basis	Bimonthly classes, 6 classes per course
Program B	1 Nurse Clinician 2 Dietitian 3 Pharmacist	1 hr. classes, x4/wk., inpatient setting; 2 hr. classes, xl/wk., in outpatient dept.
Program C	1 Health Education Coordinator 2 Dietitian 3 Nurse Educator 4 Pharmacist (consultant) 5 Psychiatrist (consultant) 6 M.D. (consultant)	4 sessions, 2 hr. each, xl/wk; repeated regularly
PRENATAL		
Program A	1 Two M.D.s 2 One R.N. 3 One Physical Therapist 4 Guest Speakers, as needed	8 classes, 1 hr. each, every other wk; 1 additional hr./mo. for tour
Program B	R.N. staff (conduct six simultaneously given courses)	5 wk. (2½ hr. sessions) course, xl/wk.; 6 wk. (3 hr. sessions) course; 1 wk. (3 hr. session) course; xl/wk.; 2 (2½ hr.) sessions; 2 other courses offered on a one-to-one basis, time varying according to need
Program C	Two "instructors"	Course I: 7 (3 hr.) sessions; Course II: 7 (3 hr.) sessions
STROKE		
Program A	1 Speech Therapist 2 Dietitian 3 Staff Nurse 4 Physical Therapist 5 Occupational Therapist 6 Social Worker 7 Neurologist 8 Attending Physician	"Regularly scheduled conferences" held by staff #1-5; Discharge conference with family and team; On-going teaching, as needed
Program B	1 Physical Therapist 2 Nursing Staff 3 Occupational Therapist	On-going Teaching
Program C	1 Nurses 2 Physical Therapists 3 Occupational Therapists 4 Social Workers 5 Physicians 6 Speech Therapists 7 Psychologists 8 Chaplain 9 Health Educator	4 (1 hr.) meetings for families of stroke patients by staff 1 - 4; On-going teaching by all
MASTECTOMY		
Program A	1 Staff Nurses 2 Patient Education Clinician	On-going; time allotted as needed; One-to-one teaching
Program B	Two R.N.s, available to staff as "resource people"	Initial assessment visit and followup visits as necessary; group teaching
Program C	1 Physical Therapist 2 Primary Nurse 3 Reach to Recovery Volunteer	One-to-one; on-going as needed

Examples of Utilization of Staff and Staff Time Spent on Patient Education (Continued)

Type of Program	Staff Participants in Program	Organization of Time
OSTOMY		
Program A	Colostomy R.N.s	Two pre-operative visits; one visit daily post-operatively
Program B	Team: 1 Physician 2 Enterostomal Therapist 3 Nursing Staff 4 Dietitian 5 Social Worker	On-going, as needed
Program C	1 R.N. 2 Health Instructor	On-going, at least 4 visits
CHRONIC OBSTRUCTIVE PULMONARY DISEASE		
Program A	Not indicated	On-going teaching
Program B	Not indicated	Individual and group teaching
MYOCARDIAL INFARCTION		
Program A	1 R.N.s 2 Dietitian 3 Pharmacist 4 Social Worker	4 (1 hr) individual sessions; 2 (1 hr) classes; telephone follow-up
Program B	1 Clinical Nurse Specialist 2 Primary Nurse 3 Staff Nurses 4 I.C.U. Nurse 5 Dietitian	Use 3 time periods; 1-post-operative 2-immediate post-operative, and 3-post-intensive care. In 1st: series of 6 visits; In 2nd: daily visits; In 3rd: 3 group classes; Also a pre-admission visit by the primary nurse
Program C	1 Dietitian 2 Physician 3 Social Worker 4 Nurse	Each discipline: 1 class/wk.; regularly scheduled
DIABETES		
Program A	1 Coordinator of Community Health Education 2 Physicians 3 Dietitians 4 Nursing Staff	2 (1 hr.) formal sessions wk.; On-going teaching depending on patient need
Program B	1 Patient Care Coordination Staff 2 Physician 3 Nursing Staff 4 Pharmacist 5 Dietitian 6 Physical Therapist	Nursing staff are responsible agents; staff #1-3 provide on-going teaching; staff #4-6 make at least one visit
Program C	1 Nurse Instructor 2 Staff Nurses 3 Dietitian	Staff #1: 5 class sessions Staff #2: reinforce classroom, one-to-one Staff #3: on-going diet teaching
PRE-OPERATIVE		
Program A	1) R.N. Instructor	1 hr. classes, offered x5/wk. Charge nurse reinforces classes on a one-to-one basis
Program B	Intensive Care Nurse	1-2 hr. one-to-one for each patient
Program C	1 R.N. 2 Respiratory Therapist 3 Anesthesiologist	Each spends time as needed with patient

Appendix 17.

Number of Hospitals Using Video Programs and Dial Access Audio Programs by State

State	Video Program	Dial Access Audio
Census Division 1		
New England	23	19
Connecticut	8	3
Maine	4	1
Massachusetts	8	12
New Hampshire	2	1
Rhode Island	0	1
Vermont	1	1
Census Division 2		
Middle Atlantic	83	55
New Jersey	18	18
New York	27	20
Pennsylvania	38	17
Census Division 3		
South Atlantic	86	34
Delaware	0	0
District of Columbia	2	0
Florida	25	9
Georgia	18	4
Maryland	8	4
North Carolina	13	3
South Carolina	9	4
Virginia	5	5
West Virginia	6	5
Census Division 4		
East North Central	157	59
Illinois	39	9
Indiana	19	10
Michigan	39	10
Ohio	36	15
Wisconsin	24	15
Census Division 5		
East South Central	32	13
Alabama	10	8
Kentucky	8	3
Mississippi	4	0
Tennessee	10	2
Census Division 6		
West North Central	67	38
Iowa	20	7
Kansas	8	4
Minnesota	14	16
Missouri	9	5
Nebraska	5	6
North Dakota	4	0
South Dakota	3	0
Census Division 7		
West South Central	32	13
Arkansas	3	1
Louisiana	5	1
Oklahoma	10	2
Texas	14	9
Census Division 8		
Mountain	43	11
Arizona	8	1
Colorado	12	4
Idaho	10	1
Montana	5	0
New Mexico	1	3
Nevada	0	0
Utah	7	2
Wyoming	0	0
Census Division 9		
Pacific	92	40
Alaska	0	0
California	62	32
Hawaii	3	0
Oregon	13	5
Washington	14	3
Total	611	282

Appendix 18.

Description of Patient Education Centers Based on Telephone Follow-Ups of the Inpatient Education Survey Responses

Thirty-six respondents identified specific areas designated as foci for patient education activities. As a result of a telephone follow-up of these responses, description of the centers routinely included one or more of the following:

1. Location/geography of center
2. Staff who manage the center
3. Users of the center
4. Mode of entry into the center
5. Materials used at the center
6. Activities occurring at the center
7. Hours of operation of the center

1. Location/geography of the Center

- Most commonly cited specific location was the classroom (12/36) (33.3%)
- Use a multipurpose room for patient education activities (4/36) (11.1%)
- Renovated areas specially for patient use (3/36) (3.3%)
- Reference to location was general, "large room," a "separate center," or non-specified (13/36) (36.1%)
- Also cited locations:
  - Cooperative Care Unit
  - Ambulatory Teaching Unit

  } Inpatient settings where patients spend time primarily for intensive teaching prior to discharge
  - Area Offices
  - Auditorium

2. Staff who manage the Center

Of the 36 respondents, 16 (44.4%) identified type of staff managing the center. In 6 cases (37.5%), nurses had sole responsibility and in 6 cases (37.5%), a combination of the following positions were mentioned or responsible:

Program Coordinators	RDs
Directors of Education	Education Specialists
Instructors	Secretaries/Typists
RNs	Volunteers
MDs	Librarians

The remaining four cases (25%) reported the position held by a general title person, for example, "staff assistant," and "inservice staff".

3. Users of the Center

Twenty-nine of the respondents (80.5%) specified the type of person using the center. Each of these cited the inpatient as a user. In addition, families were cited by nine respondents (31.0%), staff by five respondents (17.2%), outpatients by five respondents (17.2%), and the general public by four respondents (13.8%). In 27 (75%) of the hospitals, one or more specific educational programs were made available through the learning center. In descending order of frequency, the following are the programs identified:

Program	No.	%
Diabetes	23	85.2
Pre-Natal	8	29.6
Coronary	6	22.2
Ostomy	3	11.1
Respiratory	2	7.4
Pediatrics	2	7.4
CNS	1	3.7
Mastectomy	1	3.7
Nutrition	1	3.7
Obesity	1	3.7
Rehabilitation	1	3.7
Relaxation Skills	1	3.7

Two or more of these programs are provided through learning centers in 14 of 27 hospitals (51.9 %)

4. Mode of entry into the Center

The means by which users gain entry into the learning center were identified by 22 of the 36 cases (61.6%). From these cases, there were 13 (59.1%) citations of self-referral and 14 (63.6%) citations of staff referral. In self-referrals, users were informed of the center in the following ways:

	No.	%
– Suggested by staff	3	23.1
– Word of mouth	7	53.8
– Advertised in media	3	23.1

Staff-referrals (orders) were made by the following:

	No.	%
– MD only	7	50.0
– RN only	1	7.1
– MD or RN	6	42.9

5. Materials used by Center

26/36 (72.2%) of the respondents cited the materials used to provide patient education. The types of materials cited, in rank order, are:

Material	No.	%
Films	12	46.2
Pamphlets	10	38.5
A/V	8	30.8
Videotapes	6	23.1
Cassettes	5	19.2
Closed Circuit TV	4	15.4
Records	3	11.5
Books	3	11.5
Displays	2	7.7
Slides	2	7.7
Models	2	7.7
Training Guides	2	7.7
Bibliography	1	3.8
Posters	1	3.8
Flip Charts	1	3.8
Flash Cards	1	3.8
Magazines	1	3.8
Notebooks	1	3.8
	65	

The average number of material types used per learning center was 2.5.

6. Activities occurring at the Center

32/36 (88.9%) defined some activities which were held at or through the center. These are listed according to the frequency in which they are cited to occur:

Activities	No.	%
Classes	20	62.5
One-to-One staff-patient interchange	12	37.5
Provide materials to patient	7	21.9
Seminars	3	9.4
Discussions	3	9.4
Instructions	2	6.3
Providing materials to non-ambulatory patients	2	6.3
Answer Questions	2	6.3
Have Luncheons	1	3.1
Sponsor parties (pre-admission)	1	3.1
Group Therapy	1	3.1
Demonstrators	1	3.1
Lending library	1	3.1
Club	1	3.1
Go through Simulated Delivery	1	3.1

7. Hours of operation of the Center

In seven out of the 36 cases (19.4%), the time in which the learning center functioned was given. They were:

1. When the Center was itself an inpatient unit (2 or 28.6%), it was open on a 24 hour basis.
2. Some centers, though not units, were open on a 24 hour basis so patients could drop by anytime (2/7 or 28.6%).
3. Other centers were open on a limited basis, weekdays, 9–5 and/or evenings (3/7 or 42.8%).

Appendix 19.

Number of Hospitals With Specified Administrative Variables of Patient Education by Census Division and State

	Total Hospitals	Hospitals Reporting		Hospitals with Organized Programs		Person		Budget		Audit	
		No.	Percent of Total	No.	Percent Reporting	No.	Percent of Organized Programs	No.	Percent of Organized Programs	No.	Percent of Organized Programs
Census Division 1											
New England											
Maine	50	46	92.0	21	45.7	10	47.6	7	33.3	13	61.9
New Hampshire	27	24	88.8	16	66.6	6	37.5	3	18.8	15	93.8
Vermont	17	15	88.2	11	73.3	5	45.5	1	9.1	11	100.0
Massachusetts	119	106	89.1	78	73.6	31	39.7	20	25.6	59	75.6
Rhode Island	13	12	92.3	8	66.7	3	37.5	2	25.0	5	62.5
Connecticut	36	34	94.4	30	88.2	10	33.3	12	40.0	25	83.3
Census Division 2											
Middle Atlantic											
New York	309	252	81.6	174	69.0	53	30.5	44	25.3	141	81.0
New Jersey	104	97	93.3	76	78.4	36	47.4	22	28.9	59	77.6
Pennsylvania	229	207	90.4	147	71.0	59	40.1	40	27.2	113	76.9
Census Division 3											
South Atlantic											
Delaware	7	6	85.7	5	83.3	2	40.0	1	20.0	2	40.0
Maryland	46	39	84.8	28	71.8	12	42.9	8	28.6	25	89.3
Dist. of Columbia	12	10	83.3	9	90.0	2	22.2	1	11.1	7	77.8
Virginia	92	80	87.0	50	62.5	19	38.0	10	20.0	40	80.0
West Virginia	68	54	79.4	24	44.4	11	45.8	5	20.8	17	70.8
North Carolina	129	106	82.2	47	44.3	20	42.6	9	19.1	32	68.1
South Carolina	70	57	81.4	26	45.6	8	30.8	4	15.4	22	84.6
Georgia	150	114	76.0	47	41.2	25	53.2	16	34.0	35	74.5
Florida	193	165	85.5	93	56.4	35	37.6	18	19.4	71	76.3
Census Division 4											
E. North Central											
Ohio	204	176	86.3	128	72.7	48	37.5	50	39.1	100	78.1
Indiana	111	104	93.7	71	68.3	31	43.7	22	31.0	47	66.2
Illinois	241	208	86.3	149	71.6	56	37.6	38	25.5	110	73.8
Michigan	209	182	87.1	130	71.4	59	45.4	40	30.8	94	72.3
Wisconsin	144	128	88.9	89	69.5	36	40.4	32	36.0	66	74.2
Census Division 5											
E. South Central											
Kentucky	104	87	83.7	35	40.2	15	42.9	7	20.0	27	77.1
Tennessee	128	98	76.6	47	48.0	14	29.8	6	12.8	38	80.9
Alabama	128	96	75.0	48	50.0	17	35.4	7	14.6	34	70.8
Mississippi	102	65	63.7	16	24.6	6	37.5	2	12.5	12	75.0
Census Division 6											
W. North Central											
Minnesota	173	156	90.2	108	69.2	41	38.0	34	31.5	73	67.6
Iowa	135	120	88.9	95	79.2	46	48.4	23	24.2	64	67.4
Missouri	145	112	77.2	72	64.3	26	36.1	21	29.2	52	72.2
North Dakota	52	44	84.6	25	56.8	12	48.0	5	20.0	18	72.0
South Dakota	57	47	82.5	16	34.0	10	62.5	3	18.8	10	62.5
Nebraska	98	81	82.7	42	51.9	10	23.8	7	16.7	30	71.4
Kansas	144	117	81.3	48	41.0	15	31.3	9	18.8	30	62.5
Census Division 7											
W. South Central											
Arkansas	89	61	68.5	23	37.7	10	43.5	5	21.7	16	69.6
Louisiana	133	87	65.4	25	28.7	8	32.0	4	16.0	18	72.0
Oklahoma	120	84	70.0	28	33.3	6	21.4	9	32.1	21	75.0
Texas	490	322	65.7	108	33.5	35	32.4	18	16.7	66	61.1
U.S. Total	5,770	4,669	80.9	2,680	57.4	1,030	38.4	694	25.9	1,971	73.5

Number of Hospitals With Specified Administrative Variables of Patient Education by Census Division and State (Continued)

	Total Hospitals	Hospitals Reporting		Hospitals with Organized Programs		Person		Budget		Audit	
		No.	Percent of Total	No.	Percent Reporting	No.	Percent of Organized Programs	No.	Percent of Organized Programs	No.	Percent of Organized Programs
Census Division 8											
Mountain											
Montana	58	45	77.6	13	28.9	9	69.2	8	61.5	8	61.5
Idaho	46	38	82.6	22	57.9	11	50.0	5	22.7	14	63.6
Wyoming	26	19	73.1	4	21.1	0	0	0	0	0	0
Colorado	79	63	79.7	31	49.2	12	38.7	11	35.5	16	51.6
New Mexico	35	33	94.3	10	30.3	6	60.0	4	40.0	8	80.0
Arizona	55	46	83.6	26	56.5	8	30.8	8	30.8	22	84.6
Utah	34	23	67.6	17	73.9	7	41.2	4	23.5	14	82.4
Nevada	17	13	76.5	6	46.2	3	50.0	1	16.7	3	50.0
Census Division 9											
Pacific											
Washington	104	96	92.3	57	59.4	16	28.1	12	21.1	42	73.7
Oregon	74	58	78.4	37	63.8	12	32.4	10	27.0	26	70.3
California	529	408	77.1	250	61.3	93	37.2	62	24.8	189	75.6
Alaska	15	12	80.0	5	41.7	1	20.0	2	40.0	4	80.0
Hawaii	20	16	80.0	9	56.3	4	44.4	2	22.2	7	77.8
U.S. Total	5,770	4,669	80.9	2,680	57.4	1,030	38.4	694	25.9	1,971	73.5

Appendix 20.

Definition of Structural Variables

Hospitals were surveyed to identify their utilization of certain structures to support organized patient education programs and activities. These structures are defined below:

1. Policy: (Pl) — There is a written policy statement for patient education activities. A positive response to policy occurs when survey questions 1a and 16 (Section A) are answered in the affirmative.
2. Budget: (B) — There is budgeted funding for patient education activities. A positive response to budget occurs when question 5 (Section A) is answered in the affirmative.
3. Audit: (A) — An assessment of patient educational outcomes is included in any formal audit system used in the hospital. A positive response to audit occurs when any of the first 3 responses to survey question 9 (Section B) are checked.
4. Person: (Pr) — There is a person designated to coordinate inpatient education in the hospital. A positive response to person occurs when survey question 3a (Section A) is answered in the affirmative.
5. Committee: (C) — There is a committee to set general policy for all inpatient education activities in the hospital. A positive response to committee occurs when survey question 2a (Section A) is answered in the affirmative.
6. Evaluation: (E) — There is an analysis of information retained by the patient/family or an analysis of patient/family to behavior change. A positive response to evaluation occurs when an affirmative response to the fifth and/or sixth lines of response choices to question 11c (Section B) is made.

Appendix 21.

Hospitals Reporting To Have a Person Responsible for Patient Education Activities in Rank Order by State

State	Census Division	Percent of Hospitals with Organized Programs Reporting Person	State	Census Division	Percent of Hospitals with Organized Programs Reporting Person
United States		38.4	26. Minnesota	(6)	38.0
1. Montana	(8)	69.2	27. Virginia	(3)	38.0
2. South Dakota	(6)	62.5	28. Florida	(3)	37.6
3. New Mexico	(8)	60.0	29. Illinois	(4)	37.6
4. Georgia	(3)	53.2	30. Ohio	(4)	37.5
5. Idaho	(8)	50.0	31. Rhode Island	(1)	37.5
6. Nevada	(8)	50.0	32. New Hampshire	(1)	37.5
7. Iowa	(6)	48.4	33. Mississippi	(5)	37.5
8. North Dakota	(6)	48.0	34. California	(9)	37.2
9. Maine	(1)	47.6	35. Missouri	(6)	36.1
10. New Jersey	(2)	47.4	36. Alabama	(5)	35.4
11. West Virginia	(3)	45.8	37. Connecticut	(1)	33.3
12. Vermont	(1)	45.5	38. Oregon	(9)	32.4
13. Michigan	(4)	45.4	39. Texas	(7)	32.4
14. Hawaii	(9)	44.4	40. Louisiana	(7)	32.0
15. Indiana	(4)	43.7	41. Kansas	(6)	31.3
16. Arkansas	(7)	43.5	42. Arizona	(8)	30.8
17. Maryland	(3)	42.9	43. South Carolina	(3)	30.8
18. Kentucky	(5)	42.9	44. New York	(2)	30.5
19. North Carolina	(3)	42.6	45. Tennessee	(5)	29.8
20. Utah	(8)	41.2	46. Washington	(9)	28.1
21. Wisconsin	(4)	40.3	47. Nebraska	(6)	23.8
22. Pennsylvania	(2)	40.1	48. District of Columbia	(3)	22.2
23. Delaware	(3)	40.0	49. Oklahoma	(7)	21.4
24. Massachusetts	(1)	39.7	50. Alaska	(9)	20.0
25. Colorado	(8)	38.7	51. Wyoming	(8)	0
		-------- median			

Appendix 22.

Hospitals With Organized Patient Education Programs Reporting To Have a Person Responsible for Patient Education Activities

Census Division/State	Hospitals with Organized Programs		Hospitals Having Person Responsible	
	Number	Percent of Total Hospitals Reporting	Number	Percent of Hospitals with Organized Programs (Rank Order)
Census Division 1				
Maine	21	45.7	10	47.6
Vermont	11	73.3	5	45.5
Massachusetts	78	73.6	31	39.7
New Hampshire	16	66.6	6	37.5
Rhode Island	8	66.7	3	37.5
Connecticut	30	88.2	10	33.3
				$\bar{x}$ = 40.2
Census Division 2				
New Jersey	76	78.4	36	47.4
Pennsylvania	147	71.0	59	40.1
New York	174	69.0	53	30.5
				$\bar{x}$ = 39.3
Census Division 3				
Georgia	47	41.2	25	53.2
West Virginia	24	44.4	11	45.8
Maryland	28	71.8	12	42.9
North Carolina	47	44.3	20	42.6
Delaware	5	83.3	2	40.0
Virginia	50	62.5	19	38.0
Florida	93	56.4	35	37.6
South Carolina	26	45.6	8	30.8
Dist. Columbia	9	90.0	2	22.2
				$\bar{x}$ = 39.2
Census Division 4				
Michigan	130	71.4	59	45.4
Indiana	71	68.3	31	43.7
Wisconsin	89	69.5	36	40.3
Illinois	149	71.6	56	37.6
Ohio	128	72.7	48	37.5
				$\bar{x}$ = 40.9
Census Division 5				
Kentucky	35	40.2	15	42.9
Mississippi	16	24.6	6	37.5
Alabama	48	50.0	17	35.4
Tennessee	47	48.0	14	29.8
				$\bar{x}$ = 36.4

Appendix 22

Hospitals With Organized Patient Education Programs Reporting To Have a Person Responsible for Patient Education Activities (Continued)

Census Division/State	Hospitals with Organized Programs		Hospitals Having Person Responsible	
	Number	Percent of Total Hospitals Reporting	Number	Percent of Hospitals with Organized Programs (Rank Order)
Census Division 6				
South Dakota	16	34.0	10	62.5
Iowa	95	79.2	46	48.4
North Dakota	25	56.8	12	48.0
Minneosta	108	69.2	41	38.0
Missouri	72	64.3	26	36.1
Kansas	48	41.0	15	31.3
Nebraska	42	51.9	10	23.8
				$\bar{x}$ = 41.1
Census Division 7				
Arkansas	23	37.7	10	43.5
Texas	108	33.5	35	32.4
Louisiana	25	28.7	8	32.0
Oklahoma	28	33.3	6	21.4
				$\bar{x}$ = 32.3
Census Division 8				
Montana	13	28.9	9	69.2
New Mexico	10	30.3	6	60.0
Idaho	22	57.9	11	50.0
Nevada	6	46.2	3	50.0
Utah	17	23.9	7	41.2
Colorado	31	49.2	12	38.7
Arizona	26	56.5	8	30.8
Wyoming	4	21.1	0	0
				$\bar{x}$ = 42.5
Census Division 9				
Hawaii	9	56.3	4	44.4
California	250	61.3	93	37.2
Oregon	37	63.8	12	32.4
Washington	57	59.4	16	28.1
Alaska	5	41.7	1	20.0
				$\bar{x}$ = 32.4
Total U.S.	**2,680**	**57.4**	**1,030**	**38.4**

Appendix 23.

Number of Hospitals With Specified Administrative Variables* of Patient Education by State

	Pr A	Pr A E	Pr B A E	Pr	Pr B A	Pl C Pr B A E	C Pr A	C Pr B A E	Pl C Pr B A	Pl C Pr A E	C Pr A E	C Pr B A	Pl C Pr A	C Pr	Pl C Pr	Pl C A E
U.S. TOTAL	184	106	92	85	80	47	42	33	31	27	25	22	21	12	6	3
Alabama	2	3	3	2	–	–	1	–	–	2	1	–	–	–	1	–
Alaska	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	1	1	2	1	–	–	–	–	–	–	–	1	–	–	–	–
Arkansas	3	1	–	2	2	–	–	–	–	–	–	–	–	–	–	–
California	16	9	11	6	6	5	3	3	1	2	4	3	3	1	–	–
Colorado	1	1	1	1	–	1	–	–	1	–	–	–	1	–	–	–
Connecticut	1	2	1	1	1	–	–	–	–	1	–	–	–	1	–	–
Delaware	–	–	–	1	1	–	–	–	–	–	–	–	–	–	–	–
D. C.	1	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Florida	9	3	1	5	4	2	1	1	1	1	–	–	–	–	–	–
Georgia	5	3	1	1	2	3	–	–	1	–	–	1	2	–	1	1
Hawaii	1	–	1	1	–	–	–	–	–	–	–	–	–	–	–	–
Idaho	1	1	2	2	2	–	–	–	–	–	–	–	–	–	–	–
Illinois	8	10	4	2	5	1	5	1	1	2	3	1	–	1	–	–
Indiana	3	2	4	3	2	1	1	4	1	–	–	1	–	–	–	–
Iowa	6	6	3	4	1	–	–	2	5	2	2	–	3	1	1	–
Kansas	2	4	–	–	–	–	–	1	–	–	–	–	–	–	1	–
Kentucky	2	2	–	1	–	1	2	1	–	2	1	–	2	–	–	–
Louisiana	–	2	1	1	–	–	–	–	–	1	–	–	–	–	–	–
Maine	1	1	–	1	–	–	–	1	–	1	–	2	–	–	–	–
Maryland	6	–	2	–	2	1	–	–	–	–	–	–	–	–	–	–
Massachusetts	6	1	4	2	–	2	2	1	1	1	–	–	1	1	–	–
Michigan	5	8	9	5	5	2	4	–	–	1	3	–	2	1	1	–
Minnesota	7	1	1	3	3	5	5	3	1	1	1	1	–	1	–	–
Mississippi	3	–	–	–	1	–	–	–	1	–	1	–	–	–	–	–
Missouri	4	2	3	4	4	–	–	1	1	–	–	1	–	–	–	–
Montana	–	–	–	2	2	1	1	–	1	–	–	–	1	–	–	–
Nebraska	4	–	–	1	–	–	–	1	2	–	–	–	–	–	–	–
Nevada	–	–	–	1	–	–	–	–	–	–	–	–	1	–	–	–
New Hampshire	3	–	1	1	–	1	–	–	–	–	–	–	–	–	–	–
New Jersey	6	4	5	2	1	4	1	1	1	1	1	–	1	–	–	–
New Mexico	2	1	1	–	1	–	–	–	–	–	–	–	–	–	–	–
New York	11	9	5	6	3	4	–	–	3	2	–	2	–	–	–	–
North Carolina	5	1	1	4	1	–	1	–	–	–	–	–	–	–	–	–
North Dakota	2	3	2	–	–	–	2	–	2	–	1	–	–	–	–	–
Ohio	5	3	8	–	7	3	3	2	2	1	1	3	–	1	–	–
Oklahoma	2	1	–	–	2	–	–	–	–	–	–	–	–	–	–	–
Oregon	1	1	1	1	–	–	–	3	1	–	–	–	–	–	–	–
Pennsylvania	13	3	6	3	9	4	2	2	1	1	2	1	1	–	–	–
Rhode Island	1	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–
South Carolina	1	–	–	1	2	1	1	–	–	–	–	–	–	–	1	–
South Dakota	1	–	2	2	1	–	2	–	–	–	–	–	–	–	–	–
Tennessee	5	4	–	1	1	–	–	–	–	–	–	–	–	–	–	–
Texas	6	3	1	3	1	2	1	1	–	–	1	1	1	1	–	–
Utah	2	1	1	–	–	–	–	1	–	1	–	–	–	–	–	–
Vermont	3	1	–	–	–	–	–	–	–	–	–	1	–	–	–	–
Virginia	3	1	1	2	1	–	1	2	1	2	1	1	–	1	–	–
Washington	5	2	–	2	3	–	–	–	1	–	1	1	–	–	–	–
West Virginia	3	–	1	1	1	–	1	–	–	–	–	1	–	1	–	–
Wisconsin	6	3	2	2	3	3	2	1	1	2	1	–	2	1	–	–
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

*Variables are abbreviated as:

Pl – Policy
C – Committee
Pr – Person Responsible
B – Budget
A – Audit
E – Evaluation

80

Appendix 24.

Number of Hospitals With Specified Administrative Variables of Patient Education by Number of Adult Operational Programs

	Audit	Person Audit	Person Audit Evaluate	Person Budget Audit Evaluate	Person	Person Budget Audit	Policy Comm. Person Budget Audit Evaluate	Comm. Person Audit	Comm. Person Budget Audit Evaluate	Policy Comm. Person Budget Audit
U.S. Total	593	184	106	92	85	80	47	42	33	31
Less than 7 programs	327	93	43	20	53	32	6	15	6	1
More than 10 programs	135	47	33	44	15	17	32	15	21	24

	Policy Comm. Person Audit Evaluate	Comm. Person Audit Evaluate	Comm. Person Budget Audit	Policy Comm. Person Audit	Comm. Person	Policy Comm. Person	Policy Comm. Audit Evaluate
U.S. Total	27	25	22	21	12	6	3
Less than 7 programs	4	10	4	5	7	2	1
More than 10	17	11	14	8	–	2	1

Appendix 25.

Hospitals With Specified Administrative Variables of Patient Education

Variable(s)*	Total Responses No.	Responses with Less Than 7 Programs No.	%	Responses with Greater Than 10 Programs No.	%
One or Two Variables					
Pr	85	53	62.4	15	18.6
C,Pr	12	7	58.3	0	0
A	593	327	55.1	135	22.8
Pr, A	184	93	50.5	47	25.5
Four to Six Variables					
Pl,C,Pr,B,A	31	1	3.2	24	77.4
Pl,C,Pr,B,A,E	47	6	13.0	32	68.0
C,Pr,B,A,E	22	4	18.1	14	63.6
Pl,C,Pr,A,E	27	4	3.2	17	62.9
Pr,B,A,E	92	20	21.7	44	47.8

*Variables are abbreviated as:

Pl – Policy
C – Committee
Pr – Person Responsible
B – Budget
A – Audit
E – Evaluation

Appendix 26.

Hospitals Having Five or Six Specified Variables Related to Patient Education, by State

State	Variables*			
	P1,C,Pr,B,A,E	C,Pr,B,A,E	Pl,C,Pr,A,E	Total
Alabama	–	–	2	2
California	5	3	2	10
Colorado	1	–	–	1
Connecticut	–	–	1	1
Florida	2	1	1	4
Georgia	3	–	–	3
Illinois	1	1	2	4
Indiana	1	4	–	5
Iowa	–	2	2	4
Kansas	–	1	–	1
Kentucky	1	1	2	4
Louisiana	–	–	1	1
Maine	–	1	1	2
Maryland	1	–	–	1
Massachusetts	2	1	1	4
Michigan	2	–	1	3
Minnesota	5	3	1	9
Missouri	–	1	–	1
Montana	1	–	–	1
Nebraska	–	1	–	1
New Hampshire	1	–	–	1
New Jersey	4	1	1	6
New York	4	–	2	6
Ohio	3	2	1	6
Oregon	–	3	–	3
Pennsylvania	4	2	1	7
South Carolina	1	–	–	1
Texas	2	1	–	3
Utah	0	1	1	2
Virginia	–	2	2	4
Wisconsin	3	1	2	6
Total	47	53	27	107

*Variables are abbreviated as:

Pl – Policy
C – Committee
Pr – Person Responsible
B – Budget
A – Audit
E – Evaluation

Appendix 27.

Hospitals With Operational Adult Programs With a Policy, Committee, Person, Budget, Audit, Evaluation

	Total Hospitals		1–4 Programs		5–6 Programs		7–10 Programs		11–15 Programs		16–20 Programs		21–25 Programs		More than 25 Programs	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Total	47	100.0	6	12.7	0	0.0	9	19.1	8	17.0	15	31.9	8	17.0	1	2.3
6–99 Beds	3	100.0	0	0.0	0	0.0	0	0.0	0	0.0	3	100.0	0	0.0	0	0.0
100–199	8	100.0	3	37.5	0	0.0	3	37.5	2	25.0	0	0.0	0	0.0	0	0.0
200–299	14	100.0	1	7.1	0	0.0	1	7.1	3	21.5	7	50.0	2	14.3	0	0.0
300–399	10	100.0	1	10.0	0	0.0	3	30.0	1	10.0	2	20.0	2	20.0	1	10.0
400–499	4	100.0	0	0.0	0	0.0	0	0.0	0	0.0	2	50.0	2	50.0	0	0.0
500 +	8	100.0	1	12.5	0	0.0	2	25.0	2	25.0	1	12.5	2	25.0	0	0.0

Hospitals with Operational Adult Programs With a Person Responsible

	Total Hospitals		1–4 Programs		5–6 Programs		7–10 Programs		11–15 Programs		16–20 Programs		21–25 Programs		More than 25 Programs	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
U.S. Total	85	100.0	36	42.4	17	20.0	17	20.0	11	12.9	3	3.5	1	1.2	0	0.0
6–99 Beds	39	100.0	18	46.2	7	17.9	6	15.4	7	17.9	1	2.6	1	0.0	0	0.0
100–199	30	100.0	13	43.3	7	23.3	6	20.0	3	10.0	1	3.4	0	0.0	0	0.0
200–299	9	100.0	4	44.3	2	22.2	3	33.3	0	0.0	0	0.0	0	0.0	0	0.0
300–399	4	100.0	1	25.0	0	0.0	1	25.0	1	25.0	0	0.0	1	25.0	0	0.0
400–499	2	100.0	0	0.0	0	0.0	1	50.0	0	0.0	1	50.0	0	0.0	0	0.0
500 +	1	100.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.1	0	0.0	0	0.0

Appendix 28.

Number of Hospitals With Low and High Numbers of Inpatient Education Programs, by Bed Size

	Number of Hospitals	Less than 7 Programs		More than 10 Programs	
		No.	%	No.	%
U.S. Total	2,680	1,072	40.0	1,007	37.0
6–99 beds	792	422	53.3	197	24.9
100–199	724	330	45.6	235	32.5
200–299	477	148	31.0	215	45.1
300–399	286	88	30.8	135	47.2
400–499	178	37	20.8	97	54.5
500 +	223	47	21.1	128	57.4

Appendix 29.

Variables of an Overall Hospital Inpatient Education Program, by Bed Size

	Hospitals Reporting on Survey	Have Written Policy			Have General Policy Setting Committee			Designated Department Responsible			Inpatient Education Coordinator		
	No.	No.	%	Rank	No.	%	Rank	No.	%	Rank	No.	%	Rank
U.S. TOTAL	2,680	328	12.2		461	17.2		1,218	45.4		1,030	38.4	
6–99	792	93	11.7	4th	132	16.7	5th	347	43.8	3rd	302	38.1	3rd
100–199	724	80	11.0	6th	124	17.1	6th	349	48.2	2nd	308	42.5	1st
200–299	477	68	14.3	1st	80	16.8	4th	244	54.2	1st	202	42.3	2nd
300–399	286	37	12.9	3rd	51	17.8	3rd	122	42.7	4th	97	33.9	4th
400–499	178	24	13.5	2nd	32	18.0	2nd	76	42.7	5th	60	33.7	5th
500 +	223	26	11.7	5th	42	18.8	1st	80	35.9	6th	61	27.4	6th

	Hospitals Reporting on Survey	Full-Time Coordinator			Use Outside Consultants			Funds Budgeted for Patient Education		
	No.	No.	%	Rank	No.	%	Rank	No.	%	Rank
U.S. TOTAL	2,680	143	5.3		840	31.3		694	25.9	
6–99	792	17	2.1	6th	288	36.4	1st	123	15.5	6th
100–199	724	29	4.0	5th	223	30.8	3rd	166	22.9	5th
200–299	477	34	7.1	4th	139	29.1	4th	157	32.9	3rd
300–399	286	31	10.8	1st	75	26.2	6th	94	32.9	4th
400–499	178	15	8.4	2nd	56	31.5	2nd	64	36.0	2nd
500 +	223	17	7.6	3rd	59	26.5	5th	90	40.4	1st

*U.S. GOVERNMENT PRINTING OFFICE: 1977--740-116/7026